Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Illinois** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
HCBS Waiver for Persons who are Elderly

C. Waiver Number:IL.0143
Original Base Waiver Number: IL.0143.

D. Amendment Number:IL.0143.R06.04

E. Proposed Effective Date: (mm/dd/yy)

12/01/19

Approved Effective Date: 12/01/19
Approved Effective Date of Waiver being Amended: 11/01/16

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of this amendment is to effectuate guidance from the Centers for Medicare and Medicaid Services (CMS) regarding the review and rebasing of rates as well as to seek federal approval of several service rate increases included in the State's Fiscal Year 2020 budget. Rates will be increased for the following services: Emergency Home Response Service Installation (EHRS): 33.3% increase, $30.00 to $40.00; Adult Day Service (ADS): 58.5%, $9.02 to $14.30; Adult Day Service Transportation (ADST): 24%, $8.30 to $10.29;and In-Home Services: 10.29%, $18.29 to $20.28.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	

Component of the Approved Waiver	Subsection(s)
☐ Appendix A Waiver Administration and Operation	
☒ Appendix B Participant Access and Eligibility	2-a
☐ Appendix C Participant Services	
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☒ Appendix I Financial Accountability	2-a
☒ Appendix J Cost-Neutrality Demonstration	2-d

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☒ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**

Specify:

1. Request Information (1 of 3)

A. The **State** of **Illinois** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

HCBS Waiver for Persons who are Elderly

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: IL.0143
Waiver Number:IL.0143.R06.04
Draft ID: IL.020.06.04

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 11/01/16
Approved Effective Date of Waiver being Amended: 11/01/16

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Individuals aged 60 or above.

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☒ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

An amendment to the MLTSS waiver was approved on October 23, 2018 beginning January 1, 2019 – December 31, 2019.

The 1915(b) waiver states how Long Term Services and Supports (LTSS) that are defined in the 1915(c) renewal are implemented.

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☒ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☒ **A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

The Illinois' IL.13-015 1932(a) State plan amendment (SPA) to implement mandatory managed care for the adult aged, blind and disabled populations in Cook County and surrounding border counties was approved for the effective date of May 1, 2011.

The State enrolls Medicaid beneficiaries on a mandatory basis into the managed care organizations (MCOs) through the HealthChoice Illinois, which is a full-risk capitated program.

The SPA is operated under the authority granted by section 1932(a)(1)(A) of the Social Security Act. Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness, freedom of choice or comparability. The authority will not be used to mandate enrollment of Medicaid beneficiaries who are Medicare eligible, or who are First Nation/Native Americans (Indians), except for voluntary enrollment as indicated in D.2.ii of the SPA.

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☒ **A program authorized under §1115 of the Act.**

Specify the program:

The MMAI demonstration operates pursuant to Section 1115A of the Social Security Act.

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Department of Healthcare and Family Services (HFS), the state Medicaid authority, has delegated the day-to-day operations for the waiver to the Illinois Department on Aging (IDoA). Responsibilities of each agency are defined in an interagency agreement. The Department on Aging (IDoA) is the lead agency for community-based services and supports to Illinois residents, 60+ years of age. IDoA is responsible for eligibility, service plan development and implementation, enrolling waiver providers, reporting to HFS, and assuring services and providers meet established standards. HFS enrolls providers in Medicaid, provides oversight, consultation and monitoring, processes federal claims and maintains an appeal process.

The waiver is part of the Community Care Program (CCP), a larger state program operated by IDoA since 1979. The CCP offers services to persons age 60+ who meet functional and financial eligibility. Those that meet Medicaid eligibility are waiver participants. Those that do not meet Medicaid eligibility are funded with state only monies. Persons may transition in and out of Medicaid eligibility. Services offered are the same for both Medicaid and state funded participants. Just over half of the CCP participants are in the waiver.

There are 13 Planning and Service Areas (PSA) in Illinois, each managed and served by an Area Agency on Aging (AAA). IDoA works in partnership with these not-for-profit corporations and one unit of local government, the City of Chicago. AAAs provide planning and coordination of services and programs in their respective geographic areas.

An entity called the Community Care Program Advisory Committee (CCPAC) advises IDoA on an ongoing basis on reimbursement rates for CCP services, and recommendations regarding issues affecting CCP service delivery. Composition requires representatives from AAAs, Care Coordination Units (CCU), providers, advocates, adults over age 60 and state agencies. HFS attends all CCPAC meetings. HFS actively participates to clarify Medicaid or waiver policy.
Participant need for CCP services is determined by local community agencies, Care Coordination Units (CCU)/Case Management Units (CMU), which are under contract with IDoA. Care coordinators (CC) are employed by CCUs.

Care Coordinators practice a person-centered approach to assessment, care planning and on-going care coordination. Participants are provided with the opportunity to lead the care processing process. Those that choose not to are still engaged at all levels of assessment and care planning. Care Coordinators evaluate applicants need for LTSS using a standardized needs assessment instrument, the Determination of Need (DON). This tool is part of a comprehensive care assessment and designed to identify all needs and risks of the individual, including health and well-being, depression, suicide, substance abuse, and support to and from care givers. In addition, all nursing facility applicants are evaluated prior to admission and, if eligible, are offered the option of community-based LTSS. Participants in CCP are informed of their rights and responsibilities and their role in the person centered plan of care. Rights and responsibilities are defined in brochures and validated at various points of the assessment and planning processes with signatures and other affirmations documenting participation and acknowledgement. The participant and the provider(s) responsible for the implementation of the person centered plan will receive a copy of the plan.

IDoA certifies through an application process and contracts with providers of CCP services. Providers must meet standards before being certified. CCs are trained to educate participants on available providers and assist in making informed choices. Participants are given choices and may receive one or more CCP services. Services available under the waiver include homemaker, adult day care, emergency home response service and Automated Medication Dispenser. Other services are available through the Older Americans Act (OAA) and the aging network.

HFS and the IDoA maintain separate but complementary processes to monitor participant welfare, service access and quality. IDoA provides HFS with reports of their monitoring activities, including sanctions. IDoA responds to HFS reports from data obtained in site visits and file reviews conducted by federally approved Quality Improvement Organizations. Negative findings are addressed with corrective actions. HFS and IDoA meet quarterly to discuss reports that identify problematic trends and track the effects of remediation efforts to improve performance.

As of January 1, 2018, Illinois' mandatory managed care program, now called HealthChoice Illinois, will operate statewide offering providers the opportunity to contract managed care plans in all Illinois counties; numerous managed care plans will be available in Cook County. The Integrated Care Program (ICP), Family Health Plan/ACA Adults (FHP/ACA) and Managed Care Long Term Services and Supports (MLTSS) managed care programs are now incorporated in HealthChoice Illinois. Members enrolled in the Medicare Medicaid Alignment Initiative (MMAI) will not be impacted HealthChoice Illinois. Illinois received approval from the federal Centers for Medicare and Medicaid Services (CMS) to jointly implement the MMAI program on February 22, 2013. Section 1915(c) waivers impacted by MMAI were amended at that time.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the

waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of

care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

Public notice information for this amendment is located in Main - B. Optional due to character count limitations in this section.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Hartman

First Name: Bonnee

Title: Senior Public Service Administrator

Agency: Healthcare and Family Services

Address: 201 South Grand Avenue

Address 2:

City: Springfield

State: **Illinois**

Zip:

62763

Phone:

(217) 557-2349 **Ext:** ☐ **TTY**

Fax:

(217) 557-2349

E-mail:

bonnee.hartmanwalter@illinois.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

McCurdy

First Name:

Lora

Title:

Division Manager, Planning, Research & Development

Agency:

Illinois Department on Aging

Address:

1 Natural Resources Way, Suite 100

Address 2:

City:

Springfield

State: **Illinois**

Zip:

62702-1271

Phone:

(217) 558-3925 **Ext:** ☐ **TTY**

Fax:

(217) 782-4477

E-mail:

lora.mccurdy@illinois.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Kelly Cunningham

11/21/2019

State Medicaid Director or Designee

Submission Date: Nov 12, 2019

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Elwell

First Name: Douglas

Title: Medicaid Director

Agency: Healthcare and Family Services

Address: 201 South Grand Avenue East

Address 2:

City: Springfield

State: **Illinois**

Zip: 62763

Phone: (217) 782-2570 **Ext:** ☐ **TTY**

Fax: (217) 782-5672

E-mail: Doug.Elwell@Illinois.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

☐ **Replacing an approved waiver with this waiver.**

☐ **Combining waivers.**

☐ **Splitting one waiver into two waivers.**

☐ **Eliminating a service.**

☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**

☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

☐ **Reducing the unduplicated count of participants (Factor C).**

☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

DoA plans to increase the number of waiver participants served.

As a condition of approval for the Elderly waiver (effective date of September 20, 2017), a corrective action plan (CAP) has been implemented for Administrative Authority and Health and Welfare. The CAP was approved 12/06/2017, it includes this waiver and it will be fully implemented by 6/30/2019.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The State solicited public input for this Waiver Amendment in several ways. The public comment period started on Monday, July 1, 2019, and concluded on Wednesday, July 30, 2019. On July 1, 2019 the State Medicaid Agency posted on its public website a draft of the proposed Waiver Amendment. That link is here: https://www.illinois.gov/hfs/info/legal/PublicNotices/Pages/default.aspx The non-electronic method of public distribution occurred with postings at DHS local offices throughout the state (except in Cook County). In Cook County, the notice was available at the Office of the Director, Illinois Department of Healthcare and Family Services, 401 South Clinton Street, 1st Floor, Chicago, Illinois. Additionally, a telephone number was provided within the notice to request a paper copy of the proposed waiver renewal. The public notice invited comments via email or regular mail. Finally, the Illinois Department on Aging(the Operating Agency for the HCBS Waiver for Persons who are Elderly) emailed notification to its stakeholders and other interested parties.
The draft Waiver Amendment will stay on the public website until final approval from CMS.

The State issued notice to allow for tribal notification on July 1, 2019.

The State did not receive any public comments during the tribal notice period.

The State received 28 comments during the public comment period. Those comments and the State's responses are included below:

Comment 1:
I am writing to voice my support of increasing reimbursement rates for in-home, adult day, adult day transportation and emergency home response services. I work in the field of aging and witness the negative effects of turnover and under-staffing at these agencies on client care and on program efficiency. It is critical that these agencies pay living wages so that we can maintain a workforce in the aging field to cope with our aging population.
Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment 2:
I'm writing to show my support for the increase in the reimbursement rate for the HCBS Waiver for Persons who are Elderly – IL 0143. We have a top-notch adult day center in our area- Circle of Friends- and they have not had a rate increase for 10 years. It is getting harder for them to retain excellent staff and this will only get harder when the increase to the minimum wage begins if there isn't a fee increase. Thank you.
Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment 3:
Among Friends Adult Day Care provides adult day services to over 200 families at centers located in Crestwood and Glenwood, IL. Among Friends Adult Day Care urges the Illinois Department of Healthcare and Family Services and the Illinois Department on Aging to support the proposed amendment to the HCBS Waiver for Persons who are Elderly – IL 0143. Adult Day Services have not had a raise in rates for nearly 13 years.
The rate increase included in the proposed amendment would allow Adult Day Services (ADS) centers to continue to operate; to offer improved wages to workers; and allow for growth of the efficient and effective model of service for Illinois. Without this much needed increase in rates, the future of ADS in the State of Illinois is uncertain. Over the last four years we have lost 20 ADS centers in Illinois and in 2019 an additional three ADS centers have closed.
ADS enhances the quality of life for both the participants and their caregivers/families. 74% of individuals receiving adult day services live in private residences. Participants stay healthier and avoid social isolation. In fact, adult day services reduce emergency room visits and hospital readmissions.
According to research presented by the National Adult Day Services Association, "More funding for adult day services decreases Medicaid costs by reducing full-time institutional care while still providing consistent health monitoring and socialization."
Therefore, Among Friends asks that HFS and IDOA support the amendment to waiver IL 0143 so that we can continue:
- Supporting and caring for the seniors we serve;
- Supporting and caring for their families and caregivers as well;
- To offer improved wages to our staff who lovingly care for them; and
- Saving Illinois money.

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment 4:
As a physician licensed and practicing emergency medicine in the state of Illinois for 40 years, I strongly support the amendment to increase service rates of reimbursement associated with in-home, adult day, adult transportation and emergency home response services. It is apparent to me from the many geriatric patients I have cared for that these services are enabling to allow the elderly to 'age in place', often avoiding the necessity for expensive alternatives such as residential care. From an economic perspective for the state, these services can save a large expenditure. From a clinical perspective, they allow the individual the social outlets that help forestall the most serious problems for the elderly- social isolation and loneliness. This in turns minimizes depression and other health issues that ensue from said isolation. It likely also saves medical expenses due to their improved health.

As a member of the Board of Directors of the Council of Jewish Elderly Senior Life, I have also seen the adult day program first handedly, and can give testimony to its benefits both clinically and socially. From these multiple perspectives, I strongly encourage the adoption of the amendment- it is a win-win for the elderly clients, the State of Illinois, and society in general.

Thank you for allowing me to provide my thoughts on this important matter.

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #5
I strongly support the amendment to increase service rates of reimbursement associated with in-home, adult day, adult transportation and emergency home response services. It is apparent to me that these services are enabling the elderly to 'age in place' thus allowing the State to avoid the necessity for expensive alternatives such as residential care. Moreover, they allow the individual the social outlets that help forestall the most serious problems for the elderly- social isolation and loneliness. This in turn minimizes depression and other health issues that ensue from such isolation. It likely also saves medical expenses due to their improved health.

As a member of the Board of Directors of CJESENIORLIFE , I have also seen the adult day program first handedly, and can give testimony to its benefits both clinically and socially. From these multiple perspectives, I strongly encourage the adoption of the amendment- it is a win-win for the elderly clients, the State of Illinois, and society in general.

Thank you for allowing me to provide my thoughts on this important matter.

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #6:
As a senior whose parents have availed themselves of adult day services, I strongly support the amendment to increase service rates of reimbursement associated with in-home, adult day, adult transportation and emergency home response services. It is apparent to me from the many seniors I know that these services are crucial to allow the elderly to 'age in place', often avoiding the necessity for expensive alternatives such as residential care. From an economic perspective for the state, these services can save a large expenditures. From a clinical perspective, they allow the individual the social outlets that help forestall the most serious problems for the elderly, social isolation and loneliness. This in turns minimizes depression and other health issues that ensue from such isolation. It likely also saves medical expenses due to their improved health.

As a member of the Board of Directors of the Council of Jewish Elderly Senior Life, I have also seen its adult day program first hand, and can give testimony to its benefits both clinically and socially. From these multiple perspectives, I strongly encourage the adoption of the amendment- it is a win-win for the elderly clients, the State of Illinois, and society in general.
Thank you for allowing me to provide my thoughts on this important matter.

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based

supports and services.

Comment #7:
As a former social worker and board member of various social service agencies over the past 35 years, I strongly support the amendment to increase service rates of reimbursement associated with in-home, adult day, adult transportation, and emergency home response services. It is apparent to me from my years of service in the aging field that these services are enabling the elderly to 'age in place' often avoiding the necessity for expensive alternatives such as residential care. From an economic perspective for the state, these services can save much money and, from a clinical perspective, they allow the individual the social outlets that help forestall the most serious problems for the elderly: social isolation and loneliness. This in turn minimizes depression and other health issues that ensue from said isolation. It likely also saves medical expenses due to their improved health.

As a member of the Board of Directors of the Council of Jewish Elderly Senior Life, I have also seen the adult day program first hand, and can give testimony to its benefits both clinically and socially. From these multiple perspectives, I strongly encourage the adoption of the amendment- it is a win-win for the elderly clients, the State of Illinois, and society in general.

Thank you for your time.

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #8:
I am writing this letter to comment on the HFS Waiver Amendment to the HCBS Waiver for Persons who are Elderly.

I am a member of the Board of Directors and a former Treasurer of CJE SeniorLife, a non-profit agency of the Jewish Federation of Metropolitan Chicago. Our organization provides adult day and supporting transportation services for over 1200 elderly clients each month. The program provides socialization and oversight for older adults, the majority of whom have a dementia diagnosis, in a safe secure setting. It also provides a much needed respite for family caregivers.

In the eleven years since our last ADS and ADS transportation rate increase our labor and transportation costs have increased considerably. In 2018 our direct cost (excluding overhead) of providing adult day services was over $88 per client per day versus a reimbursement rate of $54, and our transportation cost per ride was over $20 versus a reimbursement rate of $8. The proposed Department's rate increases are extremely important to allow CJE SeniorLife to maintain the level and quality of services our clients and their families have come to expect.

I appreciate the opportunity to provide the above comments to the Department.

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #9:
On behalf of AARP Illinois, a non-profit, non-partisan organization that represents 1.7 million older adults across the state, we are pleased Governor Pritzker and his administration are increasing service rates of reimbursement associated with Illinois' Community Care Program's (CCP) in-home care, adult day, adult day transportation, and emergency home response services under the Waiver Amendment to the 1915(c) Home and Community Based Services (HCBS) Waiver for Persons who are Elderly.

The rate increases defined under the amendment are a step in the right direction. Our state's CCP services, positively impacted by the defined rate increases, are Illinois' frontline defense, along with Case Coordination Units, Area Agencies on Aging and family caregivers, for our 60-plus population to age with dignity in the community setting of their choice. As our aging population continues to grow, Illinois must deepen our investments and commitments to aging and family caregiver policies to ensure our aging population continues to have this critical choice of high-value care within their community. CCP remains an efficient use of state and federal resources, as well as minimizing unnecessary and costly nursing home placement of Illinois seniors.

AARP encourages the administration to find paths to greater access and availability of HCBS services and begin dialogue now with CCP service providers, family caregivers and aging advocates on service utilization, cost information, current market

conditions, and trend analysis for the next rebasing of rates of Illinois' 1915(c) HCBS Waiver. If you have any questions, please contact me at lhendren@aarp.org or 217-553-9156.

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #10:
We are in support of HCBS Waiver for Persons who are Elderly – IL 0143 to increase the rate for Adult Day Services and transportation. This is a very cost effective service that enhances the quality of lives of older adults and prevents unnecessary institutionalization. Thank you!

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #11:
As a member of the Board of Directors of the Council of Jewish Elderly Senior Life, I strongly support the amendment to increase service rates of reimbursement associated with in-home, adult day, adult transportation and emergency home response services.
I am a Long-Term Care Planning Specialist professionally, helping people plan and prepare for the time when services are needed.
It is apparent to me from my philanthropic and professional perspective that these services are enabling to allow the elderly to 'age in place. Many often avoiding the necessity for expensive alternatives such as residential care.
From an economic perspective for the state, these services can save a large expenditure. From a clinical perspective, they allow the individual the social outlets that help forestall the most serious problems for the elderly- social isolation and loneliness. This in turns minimizes depression and other health issues that ensue from said isolation. It likely also saves medical expenses due to their improved health.
I have seen the adult day program first hand and can give testimony to its benefits both clinically and socially. From these multiple perspectives, I strongly encourage the adoption of the amendment- it is a win-win for the elderly clients, the State of Illinois, and society in general.
Thank you for allowing me to provide my thoughts on this important matter.

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #12:
Hello,
I support the increase to the reimbursement levels. The care for our seniors is important and the centers need the increase to provide appropriate care.

Thank you!

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #13
I am in favor of the increase service rates of reimbursement associated with in-home, adult day and transportation in order to continue to provide the services as effectively as possible to the participants. The rate increase will help offset the increase in the minimum wage increase that will be taking effect over the next couple of years.

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #14:
To whom it may concern:

My name is Courtney and I am the supervisor at OSF Senior World, which is an adult day service in Peoria. I have seen the benefits that adult day services have on older adults and their families both professionally and personally. My uncle was only 53 years old when he was diagnosed with early onset Alzheimer's disease. My mom and her two sisters cared for their brother. He attended OSF Senior World for as long as he could until his disease progressed. This adult day service gave my uncle a sense of purpose and entertainment each day and allowed my mom and aunts to continue to work full time while also caring for their young brother. Not only have I seen what an adult day service can do for my own family, I have seen the wonderful impact it has made in the lives of many seniors and their families through my time working here at OSF Senior World. Adult day services are incredibly important to families, the individual, and the community. It is a great source of care where individuals feel that they have identity and a purpose and allows for caregivers to have a break or to continue working knowing that their loved one is being cared for.

Several adult day services around Illinois have already had to shut their door, sending many individuals to long term care possibly before they were planning on moving there. This is very sad. Individuals have the right to age in place if that is their choice and we should be doing everything we can to help aid this. Without this rate increase, I am scared to think about what would happen to adult day services and the people we care for. I hope that this rate is increased in order to help us continue to provide the great care that we do to seniors.

Thank you for your time,

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #15
I am writing in regards to the proposed Waiver amendment for Persons who are Elderly on the HCBS Waiver. I am an Adult Day Services employee and our program provides great care, but without an increase in service rate that care could be affected. An increase in our service rates is very much needed. It will allow for day programs to continue to be offered and prevent premature institutionalization.

Please consider and approve the service rate increase!

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #16
As a provider of Adult Day Services, I interact regularly with the families who entrust their loved ones to us. Most of our participants have a cognitive deficit (dementia, traumatic brain injury, etc.) which requires that they have constant supervision, both to assure their safety and also to prevent problem behaviors due to boredom or over-stimulation. We provide that to an average of 40 participants at two sites each weekday. We have 78 active participants.
Family members need our Adult Day Service to enable them to avoid placement in a skilled nursing facility, their only option if they cannot cope with providing care 24/7 themselves. It is no secret that care in skilled nursing facilities is much more expensive than supplementing family care with Adult Day Service. In addition, neither the person needing care nor their family prefer nursing home care. The families we encounter are dedicated to supporting their loved one in the community, knowing that their dignity and self-determination can be protected and supported.
Some families use our ADS to enable them to continue employment. Others use us for much-needed respite from the demands of caregiving. In addition to respite and the peace of mind of knowing their loved one is in a safe, happy place, they benefit from caregiving strategies and techniques our staff share with them. Another important benefit is that our nurses monitor each participant’s health and can alert the family to signs of a health issue.
This proposed increase in rates is essential to assuring that our adult day centers can cover their costs and continue providing the high-quality experience for which we are known. Our centers now operate at a deficit which requires us to pursue grants and donations in order to continue operations. Many Adult Day Service providers in Illinois have closed in recent years due to inadequate revenue. Four in Madison and St. Clair Counties closed. These two counties, with combined population of about 500,000, now have only three Adult Day Service sites accepting Community Care Program clients. Increased rates will assure these three remain viable and also allow us to promote these services more widely.

Response:

The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #17
The members of the Illinois Association of Community Care Program Home Care Providers (IACCPHP) support Illinois's Medicaid waiver amendment, which contains a rate increase for providers. The minimum wage is increasing in Illinois and our current rate is inadequate to cover this rate. Additionally, municipal wage rates, caregiver shortages, and additional pressures on staffing requirements have combined to make our current rate of reimbursement inadequate. This has resulted in an inability of many providers to take on new persons needing care in several areas of the state, limiting access to our services in the short term and certain to create crippling shortages of care as the minimum wage in Illinois rises. In the city of Chicago, our current rate is inadequate to cover expenses right now. If providers don't receive a rate increase, they will not be able to take on new care recipients in the most populous area of Illinois. This inadequate rate of reimbursement means that there is insufficient access to these important, cost effective programs across the state for seniors and the people who care for them. They are left with options that lead to even further social isolation as their health declines and their ability to leave their home independently decreases, further damaging their ability to remain independent.

The rate increase proposed in the Medicaid Waiver Application will provide sufficient support, until the minimum wage again increases.

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #18
The members of the Illinois Adult Day Services Association, as listed below, support Illinois's Medicaid Waiver amendment, which contains a rate increase for providers. During the last four years, we've lost over 20 centers. We have lost three centers in 2019. Only one new center has opened, leaving large areas of Illinois without a center and the remaining centers in jeopardy of closing as well. Our inadequate rate of reimbursement means that there is insufficient access to these important, cost effective programs across the state for seniors and the people who care for them. They are left with options that lead to even further social isolation as their health declines and their ability to leave their home independently decreases, further damaging their ability to remain independent. The rate increase proposed in the Medicaid Waiver Application will provide sufficient support for centers in Illinois to operate and would generate interest around the state in opening new centers, increasing access to congregate care and reducing social isolation.

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #19
As a provider of the in-home services since 2000 and servicing COOK, Lake and DuPage counties, I would like to note that proposed rate of $20.28 is essential in increasing homemaker wages to new minimum wage, but not more than that.
If we want to see this service grow, we need ongoing increases that correlate with the increases in wage that is set by city of Chicago.
Without it, we cannot afford to retain caregivers and provide stable and reliable service to our seniors.
Currently, without new reimbursement of $20.28/hour, we cannot afford to pay even the new minimum wage to caregivers who work in Chicago or attract new caregivers at all.

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #20
I would like to comment on the proposed Waiver amendment to Persons who are Elderly HCBS Waiver to increase service rates of reimbursement associated with in-home, adult day, adult day transportation and emergency home response services. I have been providing adult day services for seniors and disabled adults for 22 years at Circle of Friends Adult Day Center. We have not received a rate increase in 10 years. Many centers closed during the 2 year no budget problem. Those who sustained despite the lack of funds are barely holding on. We need an increase to provide the kinds of services our seniors deserve and want. We want to help them age in place and to do so we need the rate increase. Also the change in minimum wage will impact our staffing cost.

I strongly support the rate increases. Kathy

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #21
I am writing on behalf of Adult Day Service providers in Illinois. Throughout the state of Illinois, Adult Day Service Providers are in jeopardy of closing due to providing care for 10 yeas without a rate increase.
We continue to loose centers especially in Central and Downstate Illinois.
This places hardships on caregivers that would prefer to keep their loved ones home but limited options are available.
Adult Day Service Providers offer a safe, person centered program throughout the state.
Without this proposed rate increase more centers will be at risk of closing and more elderly moving into residential facilities premature.
I manage two ADS in Central Illinois and I ask you to pass this increase service rate associated with adult day and adult day transportation.
Thank you

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #22
I am writing on behalf of the board, staff and the communities we serve through our adult day services programs. The proposed rate increase for adult day services is critically important to the sustainability of our programs.
The rates have been static since 2008 while the needs and the cost of doing business has increased. This year the State of Illinois increased the motor fuel tax which impacts our transportation costs and began the stepped increase in the minimum wage. That does not take into account the real increase in the costs to provide quality care to our community.
The number of adult day service programs has shrunk dramatically the past few years. This increase will hopefully stop that and turn the trend back to growth.
Please contact me with any questions you might have.

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #23
Any legislation that will assist seniors in Illinois gets my support

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #24
I support this amendment

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #25
I am writing in support of HCBS Waiver for persons that are Elderly. Il-0143
An increasing percentage of our population are elderly. Many of these seniors live on fixed and limited incomes. They need assistance to live safe, quality lives.
I support this bill that will increase the reimbursement for Adullt Day Services, adult Day Transportation Services, emergency home response services and additional elderly services.
Let's help ensure our community is great for ALL ages.

Response:

The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #26
I am writing in support of HCBS Waiver for persons that are Elderly. IL-0143
An increasing percentage of our population are elderly, they need help to live safe, quality lives.
I support this bill that will increase the reimbursement for Adult Day Services, Adult Day Transportation Services, emergency home response services and additional elderly services.
Let's help ensure our community is great for ALL ages.

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #27
I am writing in support of HCBS Waiver for persons that are Elderly. IL-0143. As the Board President of Riverwalk Adult Day Services in Naperville, IL, I have seen first hand the emotional, social, cognitive and financial benefits that the elderly derive from Daytime Adult Services. With 80% of the aging population wanting to remain at home, the value of Adult day services for the participate, the caregiver and the State of Illinois is immeasurable.
An increasing percentage of our population are elderly, they need help to live safe, quality lives.
I support this bill that will increase the reimbursement levels for Adult Day Services, Adult Day Transportation Services, emergency home response services and additional elderly services.
Let's help ensure our community is great for ALL ages. Thank you!

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Comment #28
I am writing in support of HCBS Waiver for persons that are Elderly. IL-0143
An increasing percentage of our population are elderly, they need help to live safe, quality lives.

I support this bill that will increase the reimbursement for Adult Day Services, Adult Day Transportation Services, emergency home response services and additional elderly services.

Let's help ensure our community is great for ALL ages.

Thank you

Response:
The State thanks the commentor for their input. The State is committed to providing quality home and community-based supports and services.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the state Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

Illinois Department on Aging

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

Healthcare and Family Services (HFS) maintains an interagency agreement with the Illinois Department on Aging (IDoA) that outlines the HCBS waiver responsibilities of both agencies. As the Operating Agency, IDoA is responsible for participant eligibility, service plan development, Community Care Program budgeting, enrolling waiver providers, assuring service plans are implemented and that services and providers meet standards established in the approved waiver and governing rules. The Medicaid Agency enrolls providers in Medicaid, provides oversight consultation and monitoring of waiver operations, processes federal claims and maintains an appeal process. The interagency agreement is reviewed at least annually and updated as needed. The Medicaid agency's Medical Policy Review Committee reviews all waiver rule and policy changes.

HFS and IDoA meet at least quarterly to review program administration and evaluate system performance. HFS conducts routine oversight monitoring of the fiscal and program activities to assure that the State meets the federal assurances identified in the waiver.

HFS contracts with a federally certified Quality Improvement Organization (QIO) to assist HFS in its role of an administrative oversight for the Persons who are Elderly Waiver. The QIO looks at the provider's staff training documents, the amount of training hours for each staff person, the current licensure's and the results of the background checks. These documents are reviewed as part of onsite Comprehensive Provider Reviews; the QIO visits eight CCUs each year throughout Illinois, with 6 clients included in each site's sample. Sites and clients are designated by and randomly selected by the MA, respectively.

There are two broad types of program reviews: record reviews and onsite provider reviews. HFS randomly selects the participant sample from the Medicaid Management Information System (MMIS) using claims for waiver services in a specific time period. The onsite provider reviews are more comprehensive than the record reviews. The onsite reviews assess how the waiver program operates overall reviewing components of participant eligibility, service plans, provider qualifications, health and safety, care coordination and how the system operates and communicates participant needs and issues.

The MA's ongoing quality monitoring includes sharing of reports from QIO reviews with the OA as well as directly with the review site. For sites with findings, a sample Corrective Action Plan template and guidance regarding expected remediation are included as well. Review sites must submit a plan of correction to the OA for its review and any necessary follow up or clarification. The OA must provide a copy of its approval of the site's plan of correction to the MA. Other quality monitoring includes the MA's direct validation through random selection that review findings have been remediated.

In addition, MA/OA staff communicates regularly regarding any issues that arise relating to administration of the waiver. These topics include general waiver administration, quality improvement strategies, HCBS Rule transition, etc.

The MA and OA hold quarterly meetings to discuss broad topics, site reviews and remediation activities unless circumstances warrant communication prior to these meetings. The agencies also communicate regularly to follow up on issues raised during quarterly meetings.

The MA contracts with a federally certified Quality Improvement Organization to assist it in its administrative oversight of the waiver. The QIO looks at provider staff training documents, the amount of training hours for each staff person, the current licensure, and the results of background checks. These documents are reviewed as part of onsite comprehensive provider reviews; the QIO visits eight CCUs each year throughout Illinois, with 6 clients included in each site's sample. Sites and clients are designated by and randomly selected by the MA.

For MCOs, HFS and the state's External Quality Review Organization (EQRO) provide quality oversight and monitoring of the Waiver Providers through record review audits of the enrollee care plans for each Plan to monitor the quality of services and supports provided to the HCBS program Enrollees.

The state's EQRO will be performing Record Reviews to evaluate compliance with waiver performance measures as well as certain contractual components. The tool evaluates the following waiver assurances:

Level of Care—enrollee records are examined to determine completeness and accuracy of MMSE/DON completed by the Operating Agency (OA). The Plans are required to obtain a copy of the score of the current

DON obtained by the OA upon enrollment.

Qualified Providers—responsibility for provider enrollment remains with the OA. The MCOs are responsible to ensure an evaluation of the independent workers performance is completed annually, or according to the waiver requirements. Enrollee records are examined to determine the independent worker evaluation is completed.

Additional EQRO oversight of the MCOs includes review of initial case manager/care coordinator qualifications and training, as well as ongoing annual training, and oversight of case manager/care coordinator caseloads during the post implementation review and during the administrative compliance reviews.

Service Plan Development—enrollee records are examined to determine that all assessed enrollee needs, goals, and risks are addressed in the service plan; services are provided according to the plan; service plans are signed and dated by the enrollee and case manager/care coordinator; enrollees are contacted by the case manager/care coordinator per applicable waiver requirements; service plans are updated when the enrollee's needs change; and that choice of services and providers was offered to the enrollee. Service plans are also reviewed for completeness, accuracy, and timeliness.

Health, Safety, and Welfare—enrollee records will be examined to determine that enrollees are aware of how and to whom to report abuse, neglect, and exploitation; and each enrollee with an independent worker has a backup plan.

Additional oversight of the MCOs critical incident (CI) processes is the responsibility of the MA and the EQRO. The MCOs submit a detailed monthly report of critical incidents to the MA and a quarterly summary report. The EQRO reviews the policies and procedures for each MCO for reporting CIs prior to accepting enrollment to ensure adequacy of tracking software and follow-up procedures. EQRO will review a sample of CI reports during the post implementation review and during the administrative compliance reviews.

Remediation—the EQRO will submit a report of findings to HFS at the conclusion of each onsite review. The report will consist of a summary of findings for each individual record reviewed, as well as a summary of overall findings detailed by Performance Measure and contractual requirements reviewed.

Remediation activities will be tracked by the EQRO to ensure 100% remediation of findings. Timeframes for completion of remediation will be reported in 30, 60, 90, or greater than 90 days. Remediation activities will be consistent with the approved activities detailed within each Performance Measure. HFS and EQRO will work collaboratively to follow up with the MCOs to ensure remediation occurs within the required time frames.

Sampling—the MA's sampling methodology is based on a statistically valid sampling approach that uses a 95% confidence level and a 5% margin of error.

MCOs are required to submit quarterly reports, using the format required by the MA, on specific performance measures, which are described in MA's contracts with the MCOs. For each performance measure, contracts specify numerators, denominators, sampling approaches, data sources, etc. MCOs present the results to the MA in quarterly meetings.

MCO contracts include sanctions for failure to meet requirements for submissions of quality and performance measures.

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3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Care Coordination Units (CCU): Care coordination services are performed by CCUs under the Operating Agency (IDoA). CCUs perform the initial and ongoing waiver eligibility determinations for both the Fee For Service and Managed Care participants. For the Managed Care participants, the service planning and ongoing monitoring is the responsibility of the Managed Care entity.

CCU functions include:

1) Conduct a comprehensive care assessment of need and eligibility initially and at least annually or as needed based on changes in the participant's financial, support or functional needs.

2) Outline available services and choices and provide the participant with information to allow participant to make informed choices regarding services and providers.

3) Develop a person centered plan of care with the participant that best meets participant needs, with available services through the waiver or other funding sources. Provide the opportunity to the partipant/reprereresentative to lead the planning process.

4) Monitor service implementation.

5) Maintain participant records.

Illinois' mandatory managed care program, now called HealthChoice Illinois, will operate statewide effective October 1, 2018 offering providers the opportunity to contract with managed care plans in all Illinois counties; numerous managed care plans will be available in Cook County. The Integrated Care Program (ICP), Family Health Plan/ACA Adults (FHP/ACA) and Managed Long Term Services and Supports (MLTSS) managed care programs are now incorporated in HealthChoice Illinois. Members enrolled in the Medicare Medicaid Alignment Initiative (MMAI) are not impacted by HealthChoice Illinois. For those waiver participants enrolled in a Managed Care Organization (MCO), the Plans will be responsible for care coordination, service plan oversight, participant safeguards, prior authorization of waiver services, and quality assurance and quality improvement activities.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or

the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

IDoA is responsible for oversight of the Care Coordination Units.

HFS, the Medicaid Agency, conducts routine monitoring of CCU performance by selecting a sample of participant files.

The MA is responsible for assessing the performance of contracted entities in conducting waiver operational and administrative functions.

In the MA's contracts with MCOs that provide waiver services, the MA has specified for each waiver performance measure the following: responsibility for data collection; frequency of data collection/generation; sampling approach; responsible party for data aggregation and analysis; frequency of data aggregation and analysis; data source; and remediation. For each performance measure, the data source varies according to the performance measure; for many of the measures, the sources are MCO reports and External Quality Review Organization (EQRO) medical record reviews.

The data source for several measures includes customer satisfaction and Participant Outcome and Satisfaction Measures (POSM) surveys. MCOs are collecting this data either by evaluating 100 percent of records or through a representative sample of records, based on the specific performance measure.

MCOs are required to submit quarterly reports, using the format required by the MA, on specific performance measures, which are described in MA's contracts with the MCOs. For each performance measure, contracts specify numerators, denominators, sampling approaches, data sources, etc. MCOs present the results to the MA in quarterly meetings. MCO contracts include sanctions for failure to meet requirements for submissions of quality and performance measures.

The MA contracts with an EQRO. As part of the MA's quality oversight and monitoring of the waiver providers, the EQRO perform quarterly onsite audits of the enrollee care plans through Record Reviews. Per the MA's contract with the EQRO, upon completion of record reviews, the EQRO provides an Enrollee specific summary of findings by measure and a plan and Waiver specific summary report of findings and recommendations as appropriate. The report includes: Summary of non-compliance related to specific performance measures; Overall summary of record review findings; and recommendations for remediation of non-compliance. HFS and EQRO work collaboratively to follow-up with the MCOs to ensure remediation occurs within the required time frames.

HFS contracts with a federally certified Quality Improvement Organization (QIO) to assist HFS in its role of an administrative oversight for the Persons who are Elderly Waiver. The QIO looks at the provider's staff training documents, the amount of training hours for each staff person, the current licensure's and the results of the background checks. These documents are reviewed as part of onsite Comprehensive Provider Reviews; the QIO visits eight CCUs each year throughout Illinois, with 6 clients included in each site's sample. Sites and clients are designated by and randomly selected by the MA, respectively.

The MA's ongoing quality monitoring includes sharing of reports from QIO reviews with the OA as well as directly with the review site. For sites with findings, a sample Corrective Action Plan template and guidance regarding expected remediation are included as well. Review sites must submit a plan of correction to the OA for its review and any necessary follow up or clarification. The OA must provide a copy of its approval of the site's plan of correction tot he MA. Other quality monitoring includes the MA's direct validation through random selection that review findings have been remediated.

In addition, MA/OA staff communicates regularly regarding any issues that arise relating to the administration of the waiver. These topics include general waiver administration, quality improvement strategies, HCBS Rule transition, etc.

The MA and OA hold quarterly meetings to discuss broad topics, site reviews and remediation activities unless circumstances warrant communication prior to these meetings. The agencies also communicate regularly to follow up on issues raised during quarterly meetings.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The following describes the oversight of the Community Care Units (CCUs) and the Managed Care Organizations (MCO's).

HFS and IDoA maintain separate but complementary processes to monitor participant welfare, service access, and quality. The reviews are not conducted concurrently. There is some duplication of review criteria for HFS and IDoA reviews, but the same criteria are not utilized by HFS and IDoA.

The annual reviews referenced in this section by IDoA are part of continued certification that the CCUs are complying with all administrative rules and policies for the Community Care Program that includes the waiver. IDoA conducts Quality Improvement Reviews of CCUs on a three year cycle. IDoA has initiated conference calls with CCUs to discuss performance related goals and strategies for addressing performance issues.

In addition to this compliance review, IDoA provides each CCU with reports that demonstrate each agency's average score on the Determination of Need (DON) tool as well as the Participant Outcomes Status Measures (POSM). These reports compare each CCu's average score with other CCUs in their Planning and Service Area (PSA) and the statewide average.

The MA's monitoring activity is not intended to replicate the OA's reviews. The QIO performs two types of onsite reviews: Record Reviews and Comprehensive Provider Reviews. Record reviews are done through the state, based on a randomly drawn representative sample size. As noted above, there are eight Comprehensive Provider Reviews at CCUs with a total of six clients at each site. IN addition to the record review, the QIO also conducts two site visits to Community Service Providers and interviews with participants and staff from the CCU and community service provider agencies involved in their care and services.

Oversight of CCUs:

Quarterly:

IDoA aggregates and analyzes CCU performance data and is in the process of inputing the data into management reports for completion of trend analysis and identification of insufficent performance by CCUs. The collected data assist IDoA to identify potential performance problems for investigation and remediation. CCUs are required to use the feedback obtained by DoA and shared with CCUs as a central component of their own quality management strategy.

IDoA reviews reports with CCUs in joint meetings and individually as needed.
IDoA conducts calls with CCUs who perform poorly for two or more quarters to discuss corrective action strategies and monitor CCU compliance with the corrective action plans.

Annually:

IDoA conducts a desk audit of and conference call with each CCU. This audit includes a review of all performance reports, corrective action taken, and the policies and procedures maintained by the CCU.
Every three years:

IDoA conducts an onsite audit of each CCU that is a more extensive version of the desk audit.
All assessments and reviews may be done more frequently if needed. IDoA may conduct more frequent assessments or reviews based on a variety of reasons that may be the result of participant/family caregiver complaints, billing issues or an event report among others. These actions may occur if numerous event reports are received for same agency. IDoA may also conduct a Limited Scope QI onsite review or a Desk Audit. These actions are dependent upon the reasons that are triggering the need for a review.

HFS assesses the performance of the CCUs through comprehensive onsite reviews and statewide record reviews. HFS annually conducts comprehensive onsite provider reviews. A random sample of CCUs is drawn and then refined to ensure that CCUs with smaller caseloads are included. HFS makes sure that all regions are represented, and chooses two providers, usually one adult day service and one in-home care provider, serving participants whose care is coordinated by the CCU. Prior to the onsite reviews, HFS reviews IDoA records of critical events related to the CCU and providers; previous IDoA Quality Improvement and interim reviews conducted on the CCU and providers, including follow-up and actions taken. HFS documents previous IDoA findings to use to focus the onsite review and to verify corrective action

steps and ongoing compliance. During the CCU performance review, HFS completes at least six record reviews and participant interviews. Timeliness and content of assessments, service plans and case notes are part of review of records. During participant interviews HFS validates that service plans meet participant needs, are person centered including evidence that participants know how to contact the Care Coordinator. HFS also reviews policies, event reports, and personnel records for evidence of compliance with qualifications and training. Lastly, HFS interviews administrative staff about quality assurance measures; complaint receipt and handling; and the process for reporting abuse or neglect.

Reports are completed and sent to agencies (both CCU & providers) after the review, generally within 30 days. Agencies are prescribed a timeframe for completing corrective actions identified in the review. For issues of health, safety and welfare, the timeframe is generally 30 calendar days (or less depending on the severity); for most corrective actions the timeframe is 60 calendar days. If corrective action is not completed in its entirety, a second review is conducted with further corrective action. IDoA may initiate contract action, up to and including termination, for an agency with extensive correction action expectations or issues that jeopardize health, safety, and welfare of participants.

Oversight of MCOs:

The State's Quality Improvement Strategy (QIS) has been modified to assure that the MCO Plans are complying with the federal assurances and performance measures that fall under the functions delegated to them by the MA. The sources of discovery vary, and the sampling methodology for discovery is based on either a 100% review or the use of a statistically valid proportionate and representative sample. The type of sample used is indicated for each performance measure. The MA’s sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the OA and the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The MA pulls the sample annually and will adjust the methodology as additional MCOs are enrolled to provide long term services and supports.

Once the MA selects the sample, it is provided to the OA and to the MA's External Quality Review Organization (EQRO), the entity responsible for monitoring the MCOs. The EQRO determines a review schedule, based on the MCO sample sizes and performs onsite reviews for those measures that require a record review. The EQRO then sends a report of findings to the MA and the MCOs. The MCOs are required to remediate findings within required timelines. The MCOs are to report remediation activities to the MA, at least quarterly.

For the performance measures that do not require record reviews, the MCOs send routine reports (some monthly and some quarterly) to the MA. These reports are to contain discovery and remediation activity and are reviewed at least quarterly. Data sources may include the Medicaid Management Information System, the MCOs’ Information Systems, and the MCO’s critical incident reporting systems and other data sources as indicated in the waiver.

The MA meets quarterly with the MCOs to assess compliance with the waiver assurances and to identify and analyze trends based on scope and severity. Remediation activities are reviewed and systems improvements, if necessary are implemented.

As part of the State's oversight of the EQRO, the MA developed a performance measure to assure that the EQRO is completing the record reviews as required through their contract. If non-compliance is noted, the EQRO is asked to develop a corrective action plan to remediate the problem.

HFS and DOA maintain separate but complimentary processes to monitor participant welfare, service access, and quality. The reviews are not conducted concurrently. There is some duplication of review criteria for HFS and DoA reviews, but the same criteria are not used by HFS and DoA.

The annual reviews referenced in this section by IDoA are part of continued certification that the CCUs are complying with all administrative rules and policies for the Community Care Program that includes the waiver. IDoA conducts Quality Improvement Reviews of CCUs on a 3 year cycle. Within the next six months, as more information is available on the computer generated management reports, IDoA will initiate conference calls with each CCU to discuss their agency's performance.

In addition to this compliance review, IDoA provides each CCU with reports that demonstrate each agency's average score on the Determination of Need tool as well as the Participant Outcomes Status Measures (POSM). These reports compare each CCU's average score with other CCUs in their Planning and Service Area (PSA) and the statewide average.

The MA's monitoring activity is not intended to replicate the QA's reviews. The QIO performs onsite reviews. Record reviews and Comprehensive Provider Reviews. Record reviews are done throughout the State based on randomly drawn, representative sample size. As noted above, there are eight Comprehensive Provider Reviews at CCUs with a total os six clients at each site. In addition to the record review, the QIO also conducts two site visits to Community Service Providers and interviews with Participants and staff from the CCU and Community Service Provider agencies involved in their care and services.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☒	☒	☐
Waiver enrollment managed against approved limits	☒	☒	☐
Waiver expenditures managed against approved levels	☒	☒	☐
Level of care evaluation	☒	☒	☒
Review of Participant service plans	☒	☒	☒
Prior authorization of waiver services	☒	☒	☒
Utilization management	☒	☒	☒
Qualified provider enrollment	☒	☒	☒
Execution of Medicaid provider agreements	☒	☒	☐
Establishment of a statewide rate methodology	☒	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☒	☐
Quality assurance and quality improvement activities	☒	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete

the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
1A:#and% findings of non-compliance in the areas of pre-admission screening and waiver enrollment with evidence of remediation by OA within 60 days. N:#findings of non-compliance in the areas of pre-admission screening and waiver enrollment with evidence of remediation by the OA within 60 days. D:Total # of findings of non-compliance in the areas of pre-admission screening and waiver enrollment.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: Reports to MA on Delegated Tasks

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
2A:# and % fiscal estimates where waiver enrollment slots, utilization and expenditures are less than or equal to the OA estimated levels in the approved waiver. N:# fiscal estimates of waiver enrollment slots, utilization and expenditures that are less than or equal to OA estimated levels in approved waiver. D:Total # of fiscal estimates of waiver enrollment slots, utilization and expenditures.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Medical DW

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Semi-Annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Semi-Annually

Performance Measure:
3A:#and% of individual non-compliance findings re. waiver providers without a Medicaid provider agreement (MPA)on file at the MA remediated within 30 days by the OA and MCO. N:#of findings of non-compliance regarding waiver providers without a MPA on file at the MA that were remediated within 30 days by the OA and MCO. D:Total#of findings of non-compliant waiver providers without an MPA on file.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Medical DW MCO Reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
4A:# and % of rate changes submitted by the OA that are approved by the MA and submitted for Public Notice prior to implementation. N:# of rate changes submitted by the OA that are approved by the MA and submitted for Public Notice prior to implementation. D:Total # of rate methodology changes implemented.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Log of Rate Change Request

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
5A: # and % of waiver program policies submitted to the MA prior to OA dissemination and implementation. N:# of waiver program policies submitted to the MA prior to OA dissemination and implementation. D:# Total # of waiver program policies disseminated and implemented by the OA.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Log of Policy Changes

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
6A: # and % of participant reviews conducted according to the sampling methodology specified in the waiver. N:# of participant reviews conducted according to the sampling methodology specified in the waiver. D:# Total # of participant reviews required according to the sampling methodology.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: Reports to MA on Delegated Tasks

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
EQRO Reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: EQRO	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: EQRO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
7A: # and % of required MCO reports submitted according to contract requirements. N:# of MCO required reports submitted according to contract requirements. D:# Total # of MCO plan waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
8A: # and % of waiver participants provided choice by the enrollment broker when determining MCO plan selection. N:#of MCO plan waiver participants provided choice by the enrollment broker when determining MCO plan selection. D:Total # of MCO plan waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
9A: # and % of PIPs implemented in accordance with timeline in contract requirements. N:# of PIPs implemented in accordance with timeline in contract requirements. D:Total # PIPs required by contract.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
10A: # and % of waiver service providers utilized by the MCO that are an enrolled Medicaid Provider. N:# of enrolled certified waiver service providers utilized by the MCO that continue to meet applicable certification requirements. D:Total # of enrolled certified waiver service providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

MCO		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Medicaid agency, HFS, will conduct routine programmatic and fiscal monitoring for both the OA and the MCOs.

HFS and IDoA entered into an interagency agreement that is reviewed and updated on at least an annual basis. IDoA submits proposed policy changes to HFS. HFS reviews and approves these changes.

HFS and IDoA meet on a quarterly basis to review program administration and to evaluate the system performance. The quarterly meeting provides opportunities to discuss trends, issues, and remediation activities.

The OA is responsible for following up on all overdue service plans that are identified during reviews until remediation is complete. HFS works with the OA as needed to ensure required remediations have been completed.

For those functions delegated to the OA and the MCOs, the MA is responsible for oversight and monitoring to assure compliance with federal assurances and performance measures. The MA monitors both compliance levels and timeliness of remediation by the OA and MCOs.

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in HFS' contracts that provide waiver services. Contract details regarding MCO performance measures include: numerators, denominators, sampling approaches, data sources, etc. MCOs submit the reports on a quarterly basis to a SharePoint site at the MA. MA staff review reports to ensure all required information is included in the report, as well as to identify any performance issues requiring follow up with a particular MCO.

Through its contract with the EQRO, the MA monitors both compliance of PMs and timeliness of remediation for those waiver participants enrolled in an MCO through consumer surveys and quarterly record reviews.

The MA's sampling methodology for the External Quality Review Organization (EQRO) quarterly record reviews has been finalized. The EQRO is the entity responsible for monitoring MCOs. The MA's EQRO, will first determine the appropriate sample size for conducting sample by MCO and by Waiver, with Proportional random samples based on an individual MCO's waiver program distribution. Final sample size will be adjusted based on the actual MCO eligible population; MCO sample sizes will ensure a 95 percent confidence level and 5 percent margin of error. The MA will select samples by MCO and by Waiver.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Quality Improvement reviews conducted by IDoA generally utilize either a 30 day or 60 day timeframe for completing corrective actions. Corrective actions which require no more than a 30 day remediation timeframe are generally those which would jeopardize the health, safety, and welfare of participants, such as lack of criminal background checks.

1A: Findings are corrected timely by the OA. If remediation not completed within 60 days, the OA reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

2A: The OA conducts an analysis of previous enrollment, utilization, and expenditure estimates. Estimates are revised as necessary and submitted to the MA for approval. If indicated, an amendment to the waiver is submitted to CMS.

3A: The OA will obtain Medicaid provider agreements. The MCO will work with providers and the OA to obtain Medicaid provider agreements. If not qualified, the provider is dis-enrolled and the OA/MCO provides participant with other available providers. The OA/MCO trains care coordinators/case managers, if needed. If remediation not completed within 60 days, the OA/MCO reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

4A: The OA submits outstanding rate methodology changes to the MA for approval. If remediation is not within 30 days, the OA reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

5A: The OA submits outstanding policies to the MA for approval. If remediation is not within 30 days, the OA reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

6A: The OA/EQRO completes all outstanding case reviews, and reviews the case review scheduling/process to determine reasons for reviews not being conducted. If remediation not within 90 days, the OA/EQRO reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

7A: MA will require completion of overdue reports. The MCO will submit a plan of correction within 30 days.

8A: The enrollment broker will submit a plan of correction to the MA within 30 days. MA will provide training to the enrollment broker to ensure waiver participants are offered choice of MCO plans. Remediation must be completed within 60 days.

9A: The MCO will complete PIP in accordance with contract requirements. Remediation must be completed within 60 days. If not remediated within 60 days, the MA has the option to implement sanctions.

10A: Upon discovery of non-compliance, the MCO is notified to change the provider. The MCO will work with providers and the OA to become an enrolled Medicaid provider. Training for MCO case managers. Remediation within 60 days.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	65		☒
	☒	**Disabled (Physical)**	60	64	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The state further specifies its target group(s) as follows:

1. Be an Illinois resident at time of service.
2. Be Medicaid eligible
3. Be at risk of nursing facility placement as measured by the Determination of Need (DON) Level of Care assessment. Must meet the DON threshold of 29 to be eligible for the Waiver and/or nursing home placement and a maximum of 100 DON score.
4. Ability to be maintained safely in the home at a cost which does not exceed the Service Cost Maximum as measured by the DON.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Individuals who enter the waiver between the ages of 60 and 64 experience no discontinuity of service when they turn 65. Available services are the same for all waiver participants and are based on DON score not on age. After the age of 65 there is no maximum age limit for the waiver.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is *(select one)*

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

◉ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

Illinois uses the Determination of Need (DON) assessment tool for this waiver. The assessment tool was developed by researchers at the University of Illinois Chicago. The original study that validated the DON was in 1983. A revalidation conducted in 1990's and described in the journal article, Pavez, G., Cohen, D, Hagopian, M, Prohaska, T., Blaser, C and Baruner, D.; A Brief Assessment Tool for Determining Eligibility and Need for Community-Based Long-Term Services; Behavior, Health, and Aging, Vol.1, No. 2, 1990; was a cooperative venture, which included the Department of Rehabilitation Services (now DHS-Division of Rehabilitation Services (DRS)), Department of Public Aid (now Department of Healthcare and Family Services (HFS)), and the Department on Aging (IDoA). The tool was developed for two purposes: 1) as a prescreening tool for level of care determinations for this waiver and nursing facilities and 2) as a tool to assess the level or services needed which equates to a Service Cost Maximum (SCM). The research analysis also identified ranges of DON scores and associated Service Cost Maximum (SCM) levels.

Upon administration of the DON, the methodology establishes a score. An individual point count on the DON is linked to a Service Cost Maximum (SCM). This methodology allows each individual Determination of Need score a specific Service Cost Maximum rather than a range of Determination of Need scores associated to one SCM.

The state may periodically up-date SCMs based on factors such as changes in provider rates or other factors that impact the cost of waiver services.

All waiver services except the installation of the Automated Medical Dispenser and the Emergency Home Response System are included in the Service Cost Maximum. However, the monthly rates are to be included.

Monthly Service Cost Maximums follow:

Homemaker Service:

DON SCORE SERVICE MAXIMUM LEVEL

29	$508
30	569
31	630
32	691
33	752
34	813
35	874
36	934
37	995
38	1,056
39	1,117
40	1,178
41	1,239
42	1,299
43	1,361
44	1,421
45	1,483
46	1,543
47	1,604
48	1,665
49	1,725
50	1,787
51	1,847
52	1,909
53	1,969
54	2,028
55	2,091
56	2,150

57 2,213
58 2,272
59 2,335
60 2,394
61 2,455
62 2,516
63 2,577
64 2,638
65 2,698
66 2,760
67 2,820
68 2,881
69 2,942
70 3,003
71 3,064
72 3,125
73 3,185
74 3,247
75 3,307
76 3,368
77 3,429
78 3,490
79 3,551
80 3,611
81 3,673
82 3,733
83 3,795
84 3,855
85 3,917
86 3,977
87 4,037
88 4,099
89 4,159
90 4,221
91 4,280
92 4,341
93 4,402
94 4,463
95 4,524
96 4,584
97 4,646
98 4,706
99 4,767
100 4,828

Adult Day Service:

DON SCORE SERVICE MAXIMUM LEVEL

29 $1,120
30 1,302
31 1,497
32 1,689
33 1,884
34 2,077

35	2,196
36	2,312
37	2,429
38	2,547
39	2,664
40	2,783
41	2,899
42	3,017
43	3,136
44	3,252
45	3,371
46	3,488
47	3,606
48	3,723
49	3,840
50	3,958
51	4,075
52	4,194
53	4,310
54	4,427
55	4,546
56	4,661
57	4,780
58	4,898
59	5,015
60	5,132
61	5,250
62	5,367
63	5,484
64	5,603
65	5,719
66	5,838
67	5,957
68	6,072
69	6,191
70	6,309
71	6,426
72	6,543
73	6,661
74	6,778
75	6,895
76	7,014
77	7,130
78	7,249
79	7,366
80	7,482
81	7,601
82	7,718
83	7,835
84	7,953
85	8,072
86	8,187
87	8,305
88	8,422
89	8,539
90	8,658
91	8,774

92 8,893
93 9,012
94 9,127
95 9,246
96 9,364
97 9,481
98 9,598
99 9,716
100 9,833

Monthly Service Cost Maximums follow:

Homemaker Service effective 1-1-20:

DON SCORE SERVICE MAXIMUM LEVEL

29 $547
30 613
31 679
32 744
33 810
34 876
35 941
36 1,006
37 1,072
38 1,137
39 1,203
40 1,269
41 1,334
42 1,399
43 1,466
44 1,530
45 1,597
46 1,661
47 1,727
48 1,793
49 1,857
50 1,924
51 1,989
52 2,056
53 2,120
54 2,184
55 2,251
56 2,316
57 2,383
58 2,447
59 2,514
60 2,579
61 2,644
62 2,710
63 2,776
64 2,841
65 2,906
66 2,973
67 3,037
68 3,103

69	3,168
70	3,234
71	3,300
72	3,365
73	3,430
74	3,497
75	3,561
76	3,627
77	3,693
78	3,758
79	3,824
80	3,888
81	3,955
82	4,020
83	4,087
84	4,151
85	4,218
86	4,283
87	4,347
88	4,414
89	4,478
90	4,545
91	4,610
92	4,675
93	4,741
94	4,807
95	4,872
96	4,937
97	5,004
98	5,068
99	5,134
100	5,200

The cost limit specified by the state is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

◉ **Other:**

Specify:

The installation of the AMD and the EHRS are not included in the Service Cost Maximum, however, the monthly rates are included.

The new methodology establishes Service Cost Maximums based on individual Determination of Need scores, instead of a range of scores. The result is that each individual Determination of Need score has a specific Service Cost Maximum rather than a range of Determination of Need scores linking up to one Service Cost Maximum.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

A comprehensive needs assessment tool is used to determine participant's goals, strengths, risks, needs and preferences for services. The assessment looks at the participant's situation and circumstances related to all factors contributing to health, safety, well-being, quality of life and the ability to live independently in the community. It includes a review of the participant's environment in the community, as well as the participant's physical, cognitive, psychological, and social well-being.

The comprehensive assessment tool covers 11 domains: participant demographics, functional impairments [Determination of Need (DON) and Mini-Mental State Exam (MMSE)], physical health history and assessment, behavioral health (including spirituality), medications, nutritional screening, caregiver, transportation, environment, financial and legal status. The assessment also includes identification of existing support systems and the need for further evaluation by other disciplines.

The person centered plan of care that is developed in collaboration with the participant is based upon the assessment, identifies all services and supports - both formal and informal, the need for additional evaluation(s), participant expressed goals, needs and wants, and service arrangements. It also includes identification of service needs being met by existing support systems including public, private, family and community and those funded by other than the Community Care Program (waiver services). Care coordinators are encouraged to use grant funded services when available to assist in meeting participants' needs and fill-in gaps where traditional CCP services are not available or adequate.

If an individual does not meet eligibility requirements, IDoA sends the individual a Client Action Notice that informs the individual why he or she is not eligible. The notice also includes a statement that if the person does not agree with this planned action, that individual can appeal the Client Action Notice and request a hearing. The notice explains how to request an appeal with the appropriate forms enclosed. All services in effect at the time of the appeal will continue until the decision of the appeal is issued. Section F-1 describes the Fair Hearing Process in more detail.

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☒ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Temporary Service Increase (TSIs) refers to an assessment type that is completed when a current participant is at imminent risk of entering a nursing facility. Care Coordinators complete a new DON and use the appropriate service cost maximum to authorize a level of services based on the current needs of the participant. The benefit of a TSI is that due to the imminent risk of nursing home placement the new or increased level of services are expedited and are required to be implemented within two days. The care coordinator conducts another reassessment within 15-30 days depending on the status of the participant and whether they were hospitalized at the time the temporary service increase was authorized. In this way, the State allows additional services for as long as reassessments indicate that they are medically necessary. Care Coordinators are required to complete follow-up and thorough assessment within specified timeframes for participants that have had a TSI assessment. If the TSI was completed while the participant was in the hospital, the complete assessment must be completed within 15 calendar days. If the TSI was completed while the participant is residing in the community, the complete assessment must be completed within 30 days. At the time of the complete reassessment, a new DON is completed and services are established based on service needs identified at that time.

If a request for a temporary service increase is denied, care coordinators are required to refer participants to other needed services and supports.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	85090
Year 2	92054
Year 3	105618
Year 4	122447
Year 5	143101

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

◉ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ◉ **Not applicable. The state does not reserve capacity.**
- ○ **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- ◉ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

There are no specific policies related to prioritization of waiver services or applications. Persons that meet eligibility requirements are enrolled in the waiver upon completion of the waiver application. There is no waiting list for services.

For those individuals who are enrolled in MCOs, State-established policies governing the selection of individuals for entrance to the waiver remain the same as for all participants. Initial waiver eligibility is be conducted by the State contracted Community Care Units (CCUs), who are the same entities providing care coordination on behalf of the waiver participants not enrolled in a MCO. The CCUs use the same objective criteria for all participants. Selection of entrants does not violate the requirement that otherwise eligible individuals have comparable access to all services offered in the waiver.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- ○ **§1634 State**
- ○ **SSI Criteria State**
- ◉ **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- ◉ **No**
- ○ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☐ **SSI recipients**
- ☒ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☒ **Optional state supplement recipients**
- ☒ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ◉ **100% of the Federal poverty level (FPL)**
- ○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☒ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Adults age 19 and above without dependent children and with income at or below 138% of the Federal Poverty Level (Adult ACA Population) as provided in Section 1902(a)(10)(A)(i)(VIII)of the Social Security Act (the Act) and Section 42 CFR 435.119 of the federal regulations.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☐ **A special income level equal to:**

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: ☐

○ **A dollar amount which is lower than 300%.**

Specify dollar amount: ☐

☒ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☒ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount: ☐

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-c (209b State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR 435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- (●) **The following standard included under the state plan**

  (*select one*):

  - ( ) **The following standard under 42 CFR §435.121**

    Specify:

  - ( ) **Optional state supplement standard**
  - ( ) **Medically needy income standard**
  - ( ) **The special income level for institutionalized persons**

    (*select one*):

    - ( ) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

      Specify percentage:
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage:
  - (●) **Other standard included under the state Plan**

    Specify:

    The maintenance allowance for the waiver participants equals the maximum income an individual can have and be eligible under 435.217 group.
- ( ) **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- ( ) **The following formula is used to determine the needs allowance:**

  Specify:

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**
Specify:

Specify the amount of the allowance (*select one*):

○ **The following standard under 42 CFR §435.121**

Specify:

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**
Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
○ **The state does not establish reasonable limits.**
○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**
○ **A percentage of the Federal poverty level**

Specify percentage:

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

○ **The following formula is used to determine the needs allowance:**

Specify formula:

◉ **Other**

Specify:

The maintenance allowance for the waiver participants equals the maximum income an individual can have and be eligible under the 435.217 group.

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The state does not establish reasonable limits.**

○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State or §1634 State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-c also apply to B-5-f.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**

○ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

◉ **Other**

Specify:

The CCU is responsible for performing evaluations and reevaluations.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Minimum qualifications for care coordinators:
1)Be an R.N, or have a B.S.N, or have a B.A./B.S. degree in social science, social work or related field. One year of program experience, which is defined as assessment, provision, and/or authorization of formal services for the elderly, may replace one year of college education up to and including four years of experience replacing a baccalaureate degree; or,
2)Be a LPN with one year of program experience which is defined as assessment of a provision of formal services for the elderly and /or authorizing service provision; or
3)Be waived for persons hired/serving in this capacity prior to December 31, 1999.

Care coordinators must also complete the following IDoA sponsored training:
1)Preliminary Community Care Program (CCP) training which must occur prior to conducting participant assessments;
2)CCP Certification training and successfully pass the required exam within six months of completing Preliminary training; and
3)Recertification training within each 18-month anniversary of each previous certification.

Care coordinators must also complete 18 hours of documented in-service training on aging related subjects within each calendar year. For partial years of employment, training is prorated to equal 1.5 hours for each full month of employment.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The entry point into the waiver, or initial level of care determination, is through the Universal Screening process which became law on July 1, 1996 (Public Act 89-499). This law requires all individuals seeking admission into a nursing facility on or after July 1, 1996 to be screened to determine the need for nursing facility placement prior to being admitted. This screening is required regardless of income, assets or payment source. The standardized screening tool used for assessment is the Determination of Need (DON). Those individuals identified through the screening process as needing nursing facility level of care are afforded the opportunity to select a supportive living facility as long as their needs can be met in that setting.

The necessity for long term care is based on the determined need for a continuum of home and community-based services that ultimately prevent inappropriate or premature placement in a group care facility. The extent and degree of an individual's need for long term care is determined on the basis of consideration of pertinent medical, social and psychological factors as measured by application of the DON (IL-402-1230).

In order to be eligible for waiver services, the participant must be evaluated with the Illinois Determination of Need (DON) assessment and meet the minimum Level of Care. This assessment includes a Mini-Mental State Exam (MMSE) and a functional level of needs and unmet needs section. The functional status section assesses both activities of daily living (ADL) and instrumental activities of daily living (IADL). The functional areas are: eating, bathing, grooming, dressing, transferring, incontinence, managing money, telephoning, preparing meals, laundry, housework, outside of home, routine health, special health, and being alone. Each area is scored 0 - 3 for level of need, and 0 - 3 depending on the level of natural supports available to meet the need. The score of 0 is no need increasing up to total dependence with a score of 3. Mental status is evaluated using the standardized MMSE. Care coordinators receive training and guidelines for scoring each area consistently. The DON is the same criteria used to assess for nursing facility eligibility. The final score is calculated by adding the results of the MMSE, the level of impairment and the unmet need.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The CCUs conduct the level of care evaluations and reevaluations utilizing the Determination of Need as described above.

IDoA utilizes the Determination of Need (DON) assessment tool to determine level of care eligibility for the Elderly Waiver. The DON measures both activities of daily living and instrumental activities of daily living. The DON assesses fifteen areas including eating, bathing, grooming, dressing, transferring, continence, managing money, telephoning, preparing meals, laundry, housework, outside the home, routine health, special health needs and being alone. Any unmet need identified through the completion of the DON is addressed in the participant's person-centered plan of care.

Additionally, the DON includes the standardized Mini-mental State Exam (MMSE). The final score is calucated by adding the results of the MMSE, the level of impairment, and the unmet need. The minimum threshold for eligibility is a score of 29.

The re-evaluation process does not differ from the evaluation process.

For participants enrolled in an MCO, the re-evaluations are conducted by the OA.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

CCU care coordinators enter participant demographic and assessment information into the relational computerized database, Case Management Information System (CMIS). The CMIS offers one method used by the CCUs to ensure the timely reevaluation.

The CMIS generates standard reports, which also assist the CCUs as a participant tracking and caseload management system. Care coordination activities are managed by maintaining care plans and producing reports that provide care coordinators with a reminder of participant assessment due in given month. The care coordinator supervisors use the standard reports to monitor and evaluate care coordinator activities, and include current month assessment status, up-coming assessments and case management projections.

Partcipant assessment information is transmitted via CMIS to the IDoAs Internet based billing system, electronic CCP Information System (eCCPIS). CCU's periodically review the eCCPIS, to run the redetermination due or overdue report to prevent untimely annual redeterminations.

The eCCPIS reports are available to the CCUs to track when annual eligibility determinations are due. IDoA encourages the CCUs to review the eCCPIS on a regular schedule. IDoA staff review eCCPIS redetermination due reports at least twice a year.

IDoA and HFS monitor timeliness of reevaluations during monitoring activities.

For participants enrolled in an MCO, the OA will employ the same procedures to ensure its timely reevaluations of level of care.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The State requires that CCUs adhere to IDoA's standards and policies which requires that all written and/or electronic documentation related to all evaluations, reevaluations and participant care are maintained for a minimum period of 6 years after the contract terminates under which the participant was served. Active participants records can never be purged regardless of contract termination dates. CCUs are required to maintain records in a secure, confidential location that is readily accessible during this period.

For participants enrolled in an MCO, the Plans will maintain the forms. The record retention requirements will be the same for Managed Care enrollees as it is for the Fee-for-Service (FFS) enrollees. As required by CMS, the minimum will be three years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
11B: # and % of waiver applicants who have a level of care assessment that shows a reasonable indication that waiver services will be needed. N:# of waiver applicants who have a level of care assessment that shows a reasonable indication that waiver services will be needed. D:Total # of waiver applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA eCCPIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
12B:# and % of waiver participants reassessed through the redetermination process of waiver eligibility every 12 months. N:# of participants reviewed where the participant was reassessed through the redetermination process every 12 months. D:Total # of waiver participants reviewed who had reassessment due.

Data Source (Select one):
Other
If 'Other' is selected, specify:

OA eCCPIS Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
13B: # and % of waiver participants' data reviewed to ensure agreement with approval projected waiver capacity. N:Total participant enrollment data reviewed for each quarter. D:Annual projected total enrollment data for the waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA and MA Claims Data, MCO Enrollment Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
14B:# & % enrolled waiver participants where documentation supports LOC

eligibility, based on minimum DON impairment score of 15 and minimum total DON score of 29 N:# enrolled waiver participants where documentation supports the LOC eligibility, based on minimum DON impairment score of 15 and minimum total DON score of 29 D:Total # enrolled waiver participants reviewed with assessments completed

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: eCCPIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
15B:# and % of LOC determinations made by a qualified evaluator. N:# of LOC determinations reviewed made by a qualified evaluator. D:Total # of LOC determinations reviewed."

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: Training Log & eCCPIS Certification ID

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Semi-Annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Care Coordination Units (CCUs) conduct Level of Care (LOC) determinations. The state has a two-pronged approach to ensuring that LOC determinations are done in an accurate and timely fashion.

First, IDoA requires each CCU to maintain written and up-to-date policies for ensuring that all individuals potentially eligible for the waiver are given the opportunity to apply. CCUs must submit these policies to IDoA on an annual basis. IDoA reviews these policies using a checklist tool and aggregates the results in an Access database. IDoA also conducts reviews once every three years to ensure that the CCUs are following their written policies.

Second, the state maintains tracking databases in which the CCUs enter information about individual LOC determinations. These databases contain individual level and item level information from the LOC determination tools. Information is collected on a continuous basis. IDoA extracts information from these databases regarding the timeliness of the eligibility determinations and redeterminations. The information is summarized in quarterly management reports. The databases also contain edits that ensure that only individuals who meet the LOC eligibility threshold are determined eligible for the program.

For those functions delegated to the OA such as LOC determinations, the MA is responsible for oversight and monitoring to assure compliance with federal assurances and performance measures. The MA monitors both compliance levels and timeliness of remediation by the OA.

The MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the OA and the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The MA will pull the sample annually and adjust the methodology as additional MCOs are enrolled to provide long term services and supports.

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in HFS' contracts with MCOs that provide waiver services. Contracts specify numerators, denominators, sampling approaches, data sources, etc. Through its contract with the EQRO, the MA monitors both compliance of PMs and timeliness of remediation for those waiver participants enrolled in an MCO through consumer surveys and quarterly record reviews. Participants in MCOs are included in the representative sampling.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

11B: Remediation: 1. LOC is done/corrected upon discovery; 2. If eligible, no additional action; 3. If ineligible, correction of billing and claims; 4. Individual staff training as appropriate. Remediation must be completed within 60 days.

12B: Remediation: 1. LOC is completed upon discovery; 2. If eligible, no additional correction required; 3. If ineligible, billing and claims adjusted; 4. Individual receives assistance with accessing other supports and services. Remediation must be within 60 days.

13B: MA will report data to federal CMS on a quarterly basis. Increase in projected capacity will be requested if necessary based on client service population methodology.

14B: If it is discovered that the DON scores do not support LOC eligibility, the OA will require a plan of correction from the CCU to include a reassessment or justification if in error. If the justification is inadequate and/or the reassessment does not result in the required scoring, the waiver eligibility will be discontinued and the OA will assist the individual with accessing other supports and services. Federal claims will be adjusted and the OA will provide technical assistance or training to care coordinators. Remediation must be completed within 60 days.

15B: If it is determined that the evaluator is not qualified, the participant will be reassessed for LOC by a qualified evaluator (care coordinator). If the participant is then eligible, planning and services will continue as indicated. If the participant is ineligible, the individual will receive assistance with accessing other supports and services. Remediation may include CCU plan of correction or other sanctions based on scope. Remediation must be completed within 60 days.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Participant choice is a requirement of the CCP Administrative Rule 240.330. Upon assessment, participants are offered the choice between waiver services and institutional care. Care coordinators discuss service options including institutionalized care and ensure that the participant is fully aware of the pros and cons of each option. The participant must sign the form verifying that choice of setting was given. This same statement is also on the CCP form and participants verify by signature at the time of initial assessment that they were offered a choice of home and community-based services versus institutional care. Freedom of choice is also discussed in the Rights and Responsibilities brochure that is given-out to participants at each assessment. Care coordinators are required to show evidence of the participant's acknowledgement of receipt of the brochure in his/her documentation in the case notes.

Once a participant chooses to have CCP services, he or she is given a choice of provider agency (ies). Care coordinators are trained to educate participants and provide an informed choice on the available providers, their settings if service is to be delivered outside of the home, and to assist participants, if needed. IDoA utilizes a Vendor Selection Form (VSF), which the participant signs, to document participant preference of providers. If a participant has no preference, then each CCU is required to maintain a provider selection rotation list from which a care coordinator will assign a provider to a participant based on the rotation list. When a participant wishes to change providers, a new VSF can be completed and providers will be switched within fifteen days of finalizing the paperwork.

For participants enrolled in an MCO, preference for institutional or home and community-based services is documented on a Freedom of Choice form provided by the Plan and approved by the MA. The participant must sign the completed form indicating his/her choice and that he/she has made an informed decision.

MCOs are required to enter into contracts with a sufficient number of such providers within each county in the contracting area. Similar to CCU expectations, MCO care coordinators are trained to educate participants and provide an informed choice on the available providers and description of HCBS setting, if service is to be delivered outside of the home. For persons who do not express a choice amongst available contracted providers, the Plan shall fairly distribute such participants, taking into account all relevant factors, among those providers who are willing and able to accept the participant and who meet applicable quality standards.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The State requires that CCUs adhere to the Departments standards and policies which requires that all written and/or electronic documentation related to all evaluations, reevaluations and participant care are maintained for a minimum period of 6 years after the contract terminates under which the participant was served. Active participants records can never be purged regardless of contract termination dates. CCUs are required to maintain records in a secure, confidential location that is readily accessible during this period.

For participants enrolled in an MCO, the plans are required to maintain records for five years.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The State provides access to waiver services to all eligible seniors in Illinois including Limited English Proficient persons. The State provides assessment forms, brochures, and applicable paperwork that have been translated in 16 different languages to the Care Coordination Units for use. Many Care Coordination Units have bilingual Care Coordinators to perform assessments on non-English speaking clients. The State also requires that Care Coordinators use translators when necessary to complete assessments and provide care coordination services. The State reimburses the Care Coordination Units at a higher rate when a translator is required. The State also has provider agencies that target specific ethnic populations and therefore have workers that are fluent in specific languages. This information is provided to the participants during the assessment so that the participants can make an informed choice about the provider they chose. Emergency Home Reponse System (EHRS) provider standards require providers to utilize translation services that are capable of communicating in 144+ languages. The State also has arranged for technical assistance for providers through The Coalition of Limited English Speaking Elderly (CLESE) to help them through the provider application process, billing and payment issues.

For participants enrolled in an MCO, the Plan provide written materials distributed to English speaking enrollees, as appropriate, available in Spanish and other prevalent languages, as determined by the MA. Where there is a prevalent single-language minority within the low income households (5% or more such households) where a language other than English is spoken, the Plans written materials must be available in that language as well as in English.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Adult Day Service**		
Statutory Service	**In-Home Service**		
Other Service	**Automated Medication Dispenser (AMD)**		
Other Service	**Emergency Home Response Service**		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Service

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Adult Day Service is the direct care and supervision of adults aged 60 or over, in a community-based setting for the purpose of providing personal attention; and promoting social, physical and emotional well being in a structured setting. Required service components include:

Assessment of the participant's strengths and needs and development of an individual service plan specific to ADS is integrated into the participant's person-centered plan and should provide direction specific to the delivery of the ADS service and all service components to be provided or arranged by the service provider. The ADS section of the participant's person centered plan of care is to be developed and evaluated with the participant and his or her family/individual representative in coordination with the adult day service team, and it shall be developed so that it complements the participant's person centered plan. The participant shall be provided with the opportunity to lead development o fthe ADS service plan and shall have an active role in its development. The planning process shall address the personal goals of the participant, his/her strengths and needs, and any risks identified through the comprehensive assessment process.

Reassessing the participant's needs and reevaluating the appropriateness of the individualized plan of care shall be done as needed, but at least semi-annually.

A balance of purposeful activities to meet the participant's interrelated needs and interests (social, intellectual, cultural, economic, emotional, physical, and spiritual) designed to improve or maintain the optimal functioning of the participant.

Activity programming shall take into consideration individual differences in age, health status, sensory deficits, lifestyle, ethnicity, religious affiliation, values, experiences, needs, interests and abilities by providing for a variety of types and levels of involvement.

Time for rest and relaxation shall be provided as needed or prescribed.

Activity opportunities shall be available whenever the service providers facility is in operation and participants are in attendance.

A monthly calendar of activities of daily living shall be prepared and posted in a visible place along with notification/discussion of alternative options to daily activities as outlined on the calendar.

Assistance with or supervision of activities of daily living (e.g., walking, eating, toileting, and personal care) as needed.

Provision of health-related services appropriate to the participants needs as identified in the provider assessment and/or physicians orders, including health monitoring, nursing intervention on a moderate or intermittent basis for medical conditions and functional limitations, medication monitoring, medication administration or supervision of self-administration, and coordination of health services.

A meal at mid-day meeting a minimum of one-third of the Dietary Reference Intakes (DRI) as established by the Food and Nutrition Board of the National Academy of Sciences, 10th Revised Edition, 2006, no further amendments or editions included. Supplementary nutritious snacks and special diets shall also be provided as directed by the clients physician.

Agency provision or arrangement of transportation, with at least one vehicle physically accessible, to enable clients to receive adult day care service at the adult day care service providers site and participate in sponsored outings. The adult day care transportation is billed as a separate service component.

Provision of emergency care as appropriate in accordance with established adult day care service providers policies and IDoA rules.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services are provided according to the plan of care within the service cost maximum

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Service

Provider Category:

Agency

Provider Type:

Adult Day Care

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

89 Ill. Admin. Code 240

Verification of Provider Qualifications

Entity Responsible for Verification:

IDoA

Frequency of Verification:

At time of enrollment and every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

In-Home Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services consisting of general household activities (meal preparation and routine household care) provided by a trained homecare aide, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homecare aides shall meet such standards of education and training as are established by the State for the provision of these activities.

In-home serivce is defined as general non-medical support by supervised homecare aides who receive specialized training in the provision of in-home services. The purpose of providing in-home services is to maintain, strengthen, and safeguard functioning of individuals in their own homes in accordance with the authorized plan.
Specific components of in-home services shall include the following:

Teaching/performing of meal planning and preparation; routine housekeeping skills/tasks (e.g. making and changing beds, dusting, washing dishes, vacuuming, cleaning and waxing floors, keeping the kitchen and bathroom clean and laundering the participant's linens and clothing); shopping skills/tasks; and home maintenance and minor repairs.

Assisting with self-administered medication which shall be limited to:

· Reminding the participant to take his/her medications;
· Reading instructions for utilization;
· Uncapping medication containers; and,
· Providing the proper liquid and utensil with which to take medications.

Performing/assisting with essential shopping errands may include handling the participant's money (proper accounting to the participant of money handled and provision of receipts are required). These tasks shall be:
· Performed as specifically required by the plan of care; and,
· Monitored by the in-home service supervisor.

Assisting with following a written special diet plan and reinforcement of diet maintenance (can only be provided under the direction of a physician and as required in the plan of care).
Observing clients functioning and reporting to the supervisor.
Performing/assisting with personal care tasks (e.g.: shaving, hair shampooing and combing; bathing and sponge bath, shower bath or tub bath; dressing; brushing and cleaning teeth or dentures and preparation of appropriate cleaning supplies; transferring participant; and assisting participant with range of motion.

Escort to medical facilities, errands, shopping and individual business as specified in the plan of care.

In-home services may include transportation to medical facilities, or for essential errands/shopping, or for essential participant business with or on behalf of the participant as specified in the plan of care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service is limited by the service cost maximum, except for transport. There is a maximum of 100 hours hours a month. There is a process for the provision of temporary service increases. When a current participant is at imminent risk of entering a nursing facility, Care Coordinators complete a new DON and use the appropriate service cost maximum to authorize a level of services based on the current needs of the participant. Under this TSI process, new or increased level of services are expedited so that they are implemented within two days.

Care Coordinators are required to complete follow-up and thorough assessments within specified timeframes for participants that have had a TSI assessment. If the TSI was completed while the participant was in the hospital, the complete assessment must be completed within 15 calendar days. If the TSI was completed while the participant is residing in the community, the complete assessment must be completed within 30 days. Over the last two years. 3% of waiver participants utilized a temporary service increase.

The temporary service increase is utilized for participants experiencing short term, acute needs that place them at imminent risk for admission to a nursing facility. Waiver participants can request a reassessment at any point in the year whenever their needs change. As a result, additional service can be provided based on the outcome of the reassessment.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Homemaker Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: In-Home Service

Provider Category:

Agency

Provider Type:

Homemaker Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

89 Ill Admin Code 240
Homecare aides are required to have a high school or general education diploma, or one year employment in a comparable human services field, or demonstration of continued progress towards meeting the requirements of a general education diploma. Newly-hired home care aides must receive 24 hours of initial pre-service training and are subject to a competency evaluation conducted by the agency. Thereafter, a minimum of 12 hours of annual training is required.

Verification of Provider Qualifications

Entity Responsible for Verification:

IDoA

Frequency of Verification:

At time of enrollment and every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Automated Medication Dispenser (AMD)

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Automated Medication Dispenser service (AMD) is defined as “a portable, mechanical system for individual use that can be programmed to dispense or alert the participant to take non-liquid oral medications in the participant’s residence or other temporary residence in Illinois through auditory, visual or voice reminders; to provide tracking and caregiver notification of a missed medication dose; and to provide 24 hour technical assistance to the participant and responsible party for the AMD service in the home. The service may provide additional medication specific directions, or prompts to take medications via other routes such as liquid medications or injections based on individual need.

Waiver participants are afforded freedom of choice of providers regardless of whether the same AMD provider also provides EHRS services. The IDoA client agreement form contains a consent form which documents freedom of choice of provider.

The purpose of the service is to provide the participant with medication reminders when mild cognitive deficits or severe physical limitations prevent timely and safe administration of a complex medication schedule thereby promoting independence and safety of the participants in their own homes as well as potentially reducing the need for nursing home care.
The authorization of the service is determined by the Care Coordinator through a screening of the participant’s medication, medical, cognitive and physical needs; potential to benefit; availability of a willing and reliable responsible party(s) to manage medications; and commitment to use the system appropriately. The service must be authorized in the person-centered plan of care.

This service does not include Department or AMD provider medication management, oversight or handling of the participant’s medications. The participant or responsible party must be responsible for managing the acquisition of all prescribed medications, including assuring the medications are administered according to physician orders, and must manually fill the AMD. The participant or responsible party is to work with the AMD provider to program the dispenser initially and to reprogram the dispenser with any changes in the medication schedule.

In addition, the participant must have a willing family member/responsible party to be the point of contact and to act on AMD provider notification of missed medication doses and other system issues such as power outages.
The service is provided by a standalone medication dispenser base unit that is connected to and supported by a Department approved AMD provider through either the telephone line or wireless/cellular system. Electronic data on the following information is transmitted and maintained by the provider including, but not limited to: missed medication doses, notification of the responsible party when medication doses are missed, power outages or other system defaults are detected and disposition of notifications. The data will be available via electronic reports on an individual basis to the responsible party (ies) and care coordinators and in the individual or aggregate to the operating agency for the oversight of adherence to medication schedules and quality management improvement activities.

The state offers this service through the Request for Certification to assure that any willing and qualified providers have the opportunity to provide this service. Through the Request for Information and informal contacts with providers of this service, it is believed that the vast majority of providers also provide emergency home response (EHRS) services. Standards have been written to identify required automated medication dispenser service components, minimum equipment specifications and administrative requirements.

The one-time installation is separate from the monthly rental and service cost. The one-time installation cost may be combined with installation of an emergency home response system if installed at the same time by the same provider. The installation rate covers the following: maintaining adequate local staffing levels of qualified personnel to service necessary administrative activities, installation, and in-home training. The monthly rental and service rate covers the following: maintaining administrative and technical support to program machines, provide 24 hour technical assistance, signal monitoring, troubleshooting, providing machine maintenance and repair requests, sending notifications on missed medication doses and providing reports.
As specified in the IDoA Community Care Program Standards for Automated Medication Dispenser Services. This document is posted on the IDoA website at the following line -
http://www.ilga.gov/commission/jcar/admincode/089/08900240sections.html

Provider standards are in administrative rule. Providers must meet the standards as specified in Title 89 Section 240 or the Illinois Administrative Code. The web address for the AMD application is available at:
https://www.illinois.gov/aging/PartnersProviders/Procurement/Pages/certificationpacket.aspx

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The amount, duration and scope of service is based on the determination of need assessment conducted by the care coordinator and the service cost maximum determined by the DON score

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Automated Medication Dispenser Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Automated Medication Dispenser (AMD)

Provider Category:

Agency

Provider Type:

Automated Medication Dispenser Provider

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

As specified in the IDoA Community Care Program Standards for Automated Medication Dispenser Services. This document is posted on the IDoA website at the following line - http://www.ilga.gov/commission/jcar/admincode/089/08900240sections.html

Provider standards are in administrative rule. Providers must meet the standards as specified in Title 89 Section 240 or the Illinois Administrative Code. The web address for the AMD application is available at: https://www.illinois.gov/aging/PartnersProviders/Procurement/Pages/certificationpacket.aspx

Verification of Provider Qualifications

Entity Responsible for Verification:

IDoA

Frequency of Verification:

AMD providers are reviewed on the same schedule as EHRS providers - verification occurs at time of enrollment and annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Emergency Home Response Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Emergency home response service (EHRS) is defined as a 24-hour emergency communication link to assistance outside the participant's home for participants based on health and safety needs and mobility limitations. This service is provided by a two-way voice communication system consisting of a base unit and an activation device worn by the participant that will automatically link the participant to a professionally staffed support center. The support center assesses the situation and directs an appropriate response whenever this system is engaged by a participant. The purpose of providing EHRS is to improve the independence and safety of participants in their own homes in accordance with the authorized plan of care, and thereby help reduce the need for nursing home care.

Services cover both initial one time installation and monthly rental costs.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The amount, duration and scope of services is based on the determination of need assessment conducted by the care coordinator and the service cost maximum determined by the DON score.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Emergency Home Response Service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Emergency Home Response Service

Provider Category:

Agency

Provider Type:

Emergency Home Response Service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

As specified in IDoA Community Care Program Standards for Emergency Home Response Services. This document can be found at http://www.state.il.us/aging/1athome/awaq/EHRS_standards.pdf

Provider standards are in administrative rule. Providers must meet the standards as specified in Title 89 Section 240 of the Illinois Admin. Code.

Verification of Provider Qualifications

Entity Responsible for Verification:

IDoA

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☒ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Care Coordination Units (CCUs) contracted by IDoA provide care coordination services.

For participants enrolled in an MCO, case management will be the responsibility of the Plans.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All direct service workers including homecare aide and Adult Day Service employees, must have criminal background checks in accordance with the Health Care Worker Background Check Act. Requests for a health care worker background check are statewide in scope and are processed by the Illinois State Police.

Providers are responsible to complete the background check, maintain information in the employee file, and enter verification in a training tracking database or documentation in a personnel file. IDoA audits for compliance with this requirement when completing quarterly management reports, during the provider audit, and the documentation is verified during the onsite reviews.

During routine monitoring HFS reviews agency policies and employee files for evidence that criminal background checks are conducted.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services

through a state-maintained abuse registry (select one):

- (●) **No. The state does not conduct abuse registry screening.**
- ( ) **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

- [ ] **Self-directed**

☐ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

◉ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Each homecare provider agency has established an agency-specific policy regarding the hiring and assignment of homecare workers to participants who are family members. The policy must include the State policy and procedures for Family Members as Homecare Workers and must specify the circumstances under which the homecare worker shall be allowed to service family members as well as circumstances which would preclude such an assignment. Circumstances that may allow a family member to provide direct care services can include language barriers or worker availability.

The State will pay relatives to provide in-home services under specific conditions. This condition is the relative cannot be a legally responsible person to the applicant/participant, i.e. spouse, guardian, person(s) with Power of Attorney or representative payee.

Care coordinators refer interested family members to the participant’s chosen homecare provider. When developing the service plan, care coordinators will only schedule evening/weekend services based on participant's needs, not to accommodate family member availability. Family members hired as homecare workers cannot be an applicant/participant's authorized representative and may not sign the Client Agreement, Vendor Selection or Eligibility form.

Homecare providers must provide documentation substantiating the reason for hiring the family member. Providers must report the assignment of the family member and his or her relationship to the participant to the CCU; both the provider and the CCU keep documentation of the notification. Providers conduct more intensive monitoring/supervision of family members including at a minimum monthly phone monitoring during hours of service to ensure the homecare worker is there and accurately reporting hours worked and quarterly unannounced visits to ensure the homecare worker is following the plan of care.

A family member cannot be hired as a home care aide if the family member is a legally responsible person to the participant (spouse, guardian, person(s) with Power of Attorney and representative payees). Therefore, IDoA does not allow legal guardians to provide an Community Care Program services to a participant. Other non-legally responsible persons, including relatives, can be hired as a home care aide to provide services to a participant. All home care aides are hired through an agency and are required to complete all service tasks outlined on the participant's plan of care.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

IDoA is compliant with the federal "all willing and qualified provider" provision.

For HealthChoice Illinois, MCOs shall enter into a contract with any willing and qualified provider in the Contracting Area that renders waiver services so long as the provider agrees to MCO's rate and adheres to MCO's quality requirements. To be considered a qualified provider, the provider must be in good standing with the Department's FFS Medical Program. MCO may establish quality standards in addition to those State and federal requirements and contract only with providers that meet such standards. Such standards must be approved by the Department, in writing, and MCOs may only terminate a contract of a provider based on failure to meet such standards if two criteria are met: a) such standards have been in effect for at minimum one (1) year, and b) providers are informed at the time such standards come into effect.

The application and the description of the process to become a Community Care Program/Waiver certified provider is outlined on the Illinois Department on Aging (IDoA) website. All applications are reviewed by IDoA fiscal/contract staff. There are no restrictions on the application process – IDoA reviews all applications to determine compliance with the Waiver and CCP Administrative Rule requirements found at 89 Illinois Administrative Code 240.1600. In addition the link can be found at the IDoA website located at: www.illinois.gov/aging/AboutUs/Pages/rules-main.aspx.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
16C: # and % of individual findings regarding provider qualifications non-compliance that were remediated within 60 days by the OA ant MCO. N:# of

individual findings regarding provider qualifications non-compliance that were remediated within 60 days by the OA and MCO. D:Total # of individual findings regarding provider qualifications non-compliance.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports Case Manager Training; Provider Qualification Reports

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
17C: # and % of care coordinators who meet initial OA certification standards. N:# of care coordinators who met initial OA certification requirements. D:Total # of care coordinators enrolled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA: Certification reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
18C: # and % of enrolled care coordinators who continue to meet OA certification standards. N:# of care coordinators who continue to meet QA certification standards. D:Total # of OA enrolled care coordinators.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA: Certification Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
19C:# & % of newly enrolled waiver service providers who meet initial waiver provider qualifications [Incl. Adult Day Service, In-home Services (homemaker), Emerg. Home Response Service,Automated Medication Dispenser] N:#of newly enrolled waiver service providers reviewed who meet initial waiver provider quals D:Total # of newly enrolled waiver service providers reviewed, by provider type

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☒ **Other** Specify: Initially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
20C:# & % non-licensed/non-certified waiver service providers, who continue to meet waiver provider qualifications [Adult Day, In-home Services, Emergency Home Response, Automated Medication Dispenser]. N:# enrolled waiver service providers reviewed, by provider type, who continue to meet waiver provider qualifications. D:Total # enrolled waiver service providers reviewed by provider type.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: All providers reviewed once during contract period.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
21C: # and % of dieticians and nurses employed by Adult Day Service (ADS) providers who meet licensure/certification requirements. N:# of dieticians and nurses employed by ADS providers reviewed who meet licensure/certification requirements. D:Total # of dieticians and nurses employed by ADS providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify:	

	All providers reviewed once during contract period.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
22C: # and % of OA and MCO care coordinators/case managers who meet waiver provider training requirements. N:# of OA and MCO care coordinators/case managers reviewed who meet waiver provider training requirements. D:Total # OA and MCO care coordinators/case managers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:

OA Reports: Training Log MCO Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
MCO	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
23C: # and % of in-home care (homemaker) providers who meet waiver provider training requirements. N:# of in-home care (homemaker) providers reviewed who meet waiver provider training requirements. D:Total # of in-home care (homemaker) providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☒ **Other** Specify: All providers reviewed once during contract period.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Annually, IDoA completes a Contract Review Checklist at each CCU that includes items to assure compliance with the agency's contract such as operational information (hours of operation, holidays), address/location, and policies/procedures adhered to. Upon signing the checklist, each agency is certifying that they are complying with all rules, regulations, and policies of IDoA.

After conducting compliance reviews, IDoA summarizes information on each performance indicator targeting the following users: HFS, IDoA, CCUs,
providers and care coordinators. HFS and IDoA review the statewide performance data during quarterly meetings. The summarized data assists the two agencies identify potentially problematic trends and track the effects of remediation efforts to improve performance. Similarly, detailed reports for each level of entity are shared quarterly. These reports provide the basis for trend identification and specific areas of problems, leading to remediation. When individual problems with existing provider qualifications and contract compliance are identified, there is an initial effort to resolve the situation. In the case of problems identified through the complaint system, the State requires resolution within fourteen days. For other types of compliance problems, the State makes an initial request for corrective action. This corrective action request is tracked until there is a successful resolution. If there is not successful resolution, the State may take contract action under Rule 240.1665. These actions include 1) suspension of new referrals; 2) fines; or 3) contract cancellation.

HFS annually conducts comprehensive focused onsite reviews and statewide randomly selected record reviews. Service plan implementation and satisfaction is monitored during comprehensive onsite reviews.

HFS submits findings reports from routine monitoring to IDoA for follow-up and correction.

IDoA and HFS meet quarterly to discuss summary reports that include statewide data and corrective action that has been taken by IDoA. This provides an opportunity for HFS and IDoA to identify trends and issues, and to discuss remediation steps.

The Medicaid agency, HFS, will conduct routine programmatic and fiscal monitoring for both the OA and the MCOs.

For those functions delegated to the OA and the MCOs, the MA is responsible for oversight and monitoring to assure compliance with federal assurances and performance measures. The MA monitors both compliance levels and timeliness of remediation by the MCOs.

The MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the OA and the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The MA will pull the sample annually and adjust the methodology as additional MCOs are enrolled to provide long term services and supports.

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in HFS' contracts with Integrated Care Program MCOs that provide waiver services. Contracts specify numerators, denominators, sampling approaches, data sources, etc. Through its contract with the EQRO, the MA monitors both compliance of PMs and timeliness of remediation for those waiver participants enrolled in an MCO through consumer surveys and quarterly record reviews. Participants in MCOs are included in the representative sampling.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

16C. The OA/MCO obtains provider qualifications documentation. The MCO will work with providers and the OA to obtain documentation. MCOs are only allowed to use Medicaid certified providers. The provider is dis-enrolled and the OA/MCO provides participant with other available providers. The OA/MCO trains case managers, on being allowed to only use certified medical providers, if needed. Remediation must be completed within 60 days.

17C: Care coordinators cannot conduct assessments until initial training and certification is completed. Remediation would include notifying the CCU immediately the care coordinator cannot perform care coordinator functions until certification is completed and approved by the OA, and may include a plan of correction or sanction. Remediation within 30 days.

18C: The OA will notify the CCU that the care coordinator must complete recertification requirements. Remediation may include a plan of correction or sanction. Remediation with 60 days.

19C: Provider will be notified by the OA of lacking documentation. Receipt of respective provider licensure documentation or dis-enroll. Remediation within 30 days.

20C: Remove as a Medicaid provider in MMIS and request the respective provider certification documentation; Change of provider; Training for OA case managers. Remediation within 60 days.

21C: The OA will notify the ADS provider that the dietician or nurse must complete licensure/certification requirements. Remediation may include a plan of correction or sanction. Remediation must be met within 60 days.

22C: Complete care coordinator/case manager training requirements. Remediation within 60 days.

23C: Complete the training requirements. OA may require a plan of correction from the In-home care provider for how training requirements will continually be met for all in-home staff. Remediation within 60 days.

Certification training for Care Coordinator supervisors and Care Coordinators is completed by IDoA staff. Those who meet the position requirements, and who successfully complete the training, receive certification that is good for 18 months. After 18 months, their certification is extended an additional 18 months with successful completion of additional training.

Homecare Supervisors are required to successfully complete the Home care Supervisor Training by IDoA within their first 90 days of hire. IDoA's Office of Training verifies and maintains record of the certification, completion and expiration for all state required provider training.

89 III. Adm. Code outlines requirements for pre-service and annual in-service trainings for home care aides and Adult Day Service employees. Home care supervisors are also required to complete annual in-service trainings. IDoA's Office of Community Care Services verifies the completion of training requirements as part of Quality Improvement Reviews.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The State has all components of the proposed quality management strategy for this area except for the online system to track training. The online training-tracking database has been completed and is being tested internally. Provider training on use of the database is planned for early next year. Until that time, providers must maintain records and IDoA will review paper records during the annual desk audit. IDoA plans to have the training tracking database operational by December 31, 2016.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☒ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

Program eligibility is based upon scoring of an assessment tool, the Determination of Need. A service cost maximum is the total amount of funding available for services and is derived from the assessment score. This funding covers services provided in a given month.

The installation of the Personal Emergency Response system is not included in the monthly Service Cost maximum, however, the monthly rates are included.

DON

The DON is the assessment tool used to determine an individual's non-financial eligibility for CCP services based on the individual's impairment in the completion of the Mini-Mental State Examination (MMSE), Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) and the individual's need for supports not met by unpaid caregivers or other resources. This assessment is made to determine whether or not the individual is at imminent risk of institutionalization without services, and therefore eligible for placement in a nursing facility or services through the wavier.

Service Cost Maximum
The DON score corresponds to a specific service cost maximum that is the total amount of funding that may be expended on services for an eligible individual.

Participants actively participate in plan development and are informed of the various service options that are available. Participants agree to and must sign the plan of care before services are provided. Participants and their providers are always given copies of complete plans of care.

Waiver services even if limited, are supplemented by other IDoA services, such as home delivered meals, congregate meals, transportation, and respite. Care Coordinators are trained to incorporate all available local, state and federal services when developing a participant's plan of care.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Settings in this waiver will comply with federal HCBS requirements per Attachment #2 in this renewal application.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Plan of Care (POC)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:

Minimum qualifications for care coordinators:

1) Be an R.N, or have a B.S.N, or have a B.A./B.S. degree in social science, social work or related field. One year of program experience, which is defined as assessment, provision, and/or authorization of formal services for the elderly, may replace one year of college education up to and including four years of experience replacing a baccalaureate degree; or,
2) Be a LPN with one year of program experience which is defined as assessment of a provision of formal services for the elderly and /or authorizing service provision; or
3) Be waived for persons hired/serving in this capacity prior to December 31, 1991. Provision of a waiver for care coordinators hired prior to December 31, 1991 was based on their years of experience. These care coordinators must maintain certification for a case manager and must also follow in-service requirements.

Care coordinators must also complete the following Department sponsored training:

1) Preliminary Community Care Program (CCP) training that must occur prior to conducting participant assessments;
2) CCP Certification training and successfully pass the required exam within six months of completing Preliminary training; and
3) Recertification training within each 18-month anniversary of each previous certification.

Care coordinators must also complete 18 hours of documented in-service training on aging related subjects within each calendar year. For partial years of employment, training shall be prorated to equal 1.5 hours for each full month of employment. Documented participation in in-house staff training and/or local, state, regional, or national conferences on aging related topics in addition to the Department sponsored Preliminary, Certification and Recertification training will qualify as in-service training on an hour-for-hour basis.

For participants enrolled in an MCO, the care coordinators are responsible for service plan development. Qualifications for the care coordinators vary within each of the Plans, and are assigned based on individual need and identified risk. At minimum, qualifications include the following license or education level:

Registered Nurse (RN) in Illinois
Bachelor's degree in nursing, social sciences, social work or related field
Licensed practical nurse (LPN) with one (1) year experience in conducting comprehensive assessments and provision of formal service for the elderly
One (1) year of satisfactory program experience may replace one year of college education, at least four (4) years of experience replacing baccalaureate degree

The MCO care coordinators are required to complete 20 hours of training, initially and annually, as specified in the MCO contract. They are not required to complete the Department sponsored training; however, if they do complete the Department sponsored training, it will be counted toward their total hours of required training.

MCO care coordinators must be trained on topics specific to the type of HCBS Waiver Enrollee they are serving. For the Elderly Waiver, training must include Aging related subjects.

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) Supports and information available to participant/customer

OA Process:

Person-centered planning begins with a person centered assessment and re-assessment conducted by a Care Coordinator from the local Care Coordination Unit, which is an independent Care Coordinator and not linked to any provider of service. DoA is in the process of analyzing its current forms and documents to determine compliance with the HCBS regulations specific to the person-centered planning requirements. DoA recognizes that the development of the necessary skill set and the approach to participant/customer inclusion at all levels of assessment and participant centered plan of care development will require on-going training and is a critical component in the hiring and supervision of persons performing care coordination.

Routine practice of the Care Coordinator includes asking the waiver participant/customer who, if any individuals the participant/customer would like to attend the care planning session. As the date and time is set for the care planning assessment and discussion, the care coordinator is to make every accommodation possible to satisfy and include all persons identified by the participant/customer. It is expected that in all conversations between the care coordinator and the participant/customer be participant/customer focused, constantly reinforcing that planning is a collaborative effort, enabling the waiver participant/customer to lead the process to the best of his/her abilities and that the outcome of the process is a Participant Centered Plan of Care in which the plan is one that is owned and agreed to by the participant/customer.

Written materials pertaining to the waiver are being updated to ensure language in all materials informing the waiver participant/customer of his/her rights comport with HCBS rules. These documents include statements in the Home Care Consumer Bill of Rights and Things You Need to Know informing the participant of their right to appeal. These documents includes statements pertaining to the participant's right to include those he/she wishes to participate in all assessments and the development of a plan of care reflective of the individual's needs, preferences, goals and health status.

In addition, the language in these documents articulate the ability of the participant/customer to include all persons chosen by the participant/customer to be included at all informational gathering, assessment and reassessment meetings. Language states that times of these meetings should occur at times and locations convenient with the understanding that to fully assess participant/customers needs, it is to be completed in their home environment and that the waiver participant/customer is in essence the driver of the participant/customer centered plan development. Language states that the conversation between the waiver participant/customer and the care coordinator is to be goal centered.
In order to achieve a holistic person-centered approach the OA has set the expectation that care coordination encompasses a comprehensive assessment of the participant's situation and circumstances related to all factors contributing to health, welfare, safety, community integration, quality of life, ability to live independently in the community and the participant's vision for his/her quality of life. The CCP utilizes the Comprehensive Care Coordination (CCC) assessment tool for this holistic approach. The CCC is a process that utilizes a tool that includes a review of the participant's environment in the community, physical, cognitive, psychological/emotional, and social well-being. It also includes identification of existing support systems and the need for further evaluation(s) by other disciplines. The CCC tool covers eleven domains; participant demographics, physical health history, behavioral health, Determination of Need (DON) & Mini-Mental Status Exam (MMSE) evaluation, medications, nutrition, caregiver, transportation, environmental, financial and legal. Information collected in the CCC assessment is used to help the care coordinator and the participant form the POC. Risk factors, such as depression, alcohol and substance abuse, medications, caregivers, health, falls and behaviors, are identified and addressed throughout the domains of the CCC assessment tool. Care coordinators are trained to discuss potential risks with the client and work together to develop a POC that will minimize or eliminate the risk.

The CCC prompts the Care Coordinators to ensure all areas of a holistic assessment is captured and what the participant hopes to achieve from the delivery of waiver services, as well as other available options is included. The Person Centered Plan of Care that emerges from this assessment and conversation is one that encompasses all participant needs, desires, goals and vision and links the participant with an array of options, not just those programs and services that are components of the waiver.

The Plan of Care that is the result of this comprehensive assessment identifies what does the waiver participant hope to realize as life goals and desires and what supports; both waiver services and non-waiver services can assist the

participant/customer in actualizing these goals and desires. The written documentation in the development of the Plan of Care and other assessment forms utilized during the assessment/reassessment processes indicate that the waiver participant exercised choice in the decision making process.

As mentioned above, the Home Care Consumer Bill of Rights which was enacted August 15, 2014 into State law outlines the State's commitment to assuring the rights of all home care consumers emphasizes participation in planning, self-determination, choice, dignity and individuality. This Consumer Bill of Rights is to be provided to and discussed with the participant/customer at all assessments and sessions where planning occurs.
Assessments and Reassessments are based upon changes in participant circumstances such as following a recent hospital visit, loss of a caregiver and/or changes in the person's health status. The process described above at all types of assessments and follow-up conversations regarding care plan implementation.

MCO Process:

The same processes of how an assessment and/or reassessment described above by the OA is expected of care coordination provided by Managed Care. MCO care coordinators are expected to engage the participant/customer and assure that he/she directs the process as much as possible by asking and encouraging at all levels of the assessment, reassessment and care planning interview processes. All accommodations are to be given to anyone he/she wishes to include in the discussions and meetings to develop a holistic person centered plan of care.

As stated as critical element of the process, is the professional practice of the MCO Care Coordinator. The engagement and inclusion of the participant/customer and those that he/she designates to be included in the process requires training and expertise by the Care Coordinator. The MCO assessment tools and those given to them by the OA, prompts the care coordinators to ensure all areas of a holistic assessment is captured and that it reflects the goals, desires and needs of the participant/customer. The resulting Participant Plan of Care is to reflect what the Participant/customer hopes to achieve and meet the participant/customer expectations, to the best of ability of available programs and services that include waiver and non-waiver programs and services. The Person Centered Plan of Care that emerges from this assessment and conversation is one that encompasses all participant/customer needs, desires, goals and vision and links the participant/customer with the whole array of options, not just those programs and services that are components of the waiver.

The MCO entities have assessment tools that contain components that are used to elicit and achieve holistic and comprehensive information from the participant/customers to support a person centered service plan of care. Components in the assessments include, but are not limited to cognitive/emotional ADLS, IADLS, behavioral health, medication, living supports, environmental conditions, and health care information. The Plans review the State's assessment/Level of Care instruments, conducted by the OA. In addition, the MCO care coordinator's assessment secures information that include the member's strengths, needs, personal goals and desires, levels of functioning and risk. The participant/customer's person centered plan of care is to be reviewed within 90 days of initial implementation of the service and reassessed as needed. A re-assessment is to occur, at a minimum annually. All care coordinators are trained to discuss potential risks with the client and work together to develop a POC that will minimize or eliminate risk. Through the assessment and care planning process, the participant/customer's goals and the strengths and barriers to achieving these goals are identified.

MCO Care Coordinators are also required to enable as much choice as possible with the MCOs offering options of providers in order to accommodate participant/customer preferences and choice. MCO Care Coordinators must offer contract to all working and qualified providers. By terms of their contract with the MA, the Plan must enter into contracts with a sufficient number of such Providers within each county in the Contracting Area to assure that the Affiliated Providers served at least eighty percent (80%) of the number of Participant/customers in each county who were receiving such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) of such Providers, so long as such Providers accept Contractor's rates, even if one (1) served more than eighty percent (80%) of the Participant/customers, unless the Department grants Contractor an exception.

(b) The participant/customer's authority to determine who is included in the process. (OA and MCO Processes)

The participant/customer's right to determine who is in included in the process is articulated in the Home Care Consumer Bill of Rights. This is to be given to all participant/customers at the time of assessments and reassessments. Also, as

described in (a) above for both the OA Care Coordinators and those of the MCOs, Care Coordinator's practice requires that they routinely inquire and document the participant/customer's authority to determine who is included in the process. This is documented in the Participant Plan of Care.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The State is committed to implementation of a person-centered planning process. The care coordinators are trained to include the participant in every aspect of the assessment and service plan development, including providing the participant and his/her representative with the opportunity to lead the planning process.

For the OA, the CCU contacts the participant or authorized representative, usually by phone, prior to the scheduling of the assessment. Assessments are generally conducted in the participant's residence except for redeterminations of Adult Day Service (ADS) participants, which may be conducted at the ADS site. The care coordinator schedules the visit around the participant and other parties that the participant wishes to have included.

a) Development of plan, participation in process, and timing of the plan:

OA Process:

The care coordinators conduct a face-to-face comprehensive assessment of the participant. The assessment contains a "goals of care" section where participants express their goals, which include those related to service needs, overall life goals or desires and their expectations for care. Goals are holistic and are not restricted to only needs that will be addressed by waiver services. If the waiver participant voices a desire to attend a house of worship or go to the lectures at the library, these should appear under goals and be articulated in the Participant Centered Plan of Care. Participants and anyone they wish to include are to have an active role in the development of the Person Centered Plan of Care. This includes choosing services and service providers. The face-to-face assessment is conducted in the participant’s residence as this is most convenient and enables the care coordinator to see the participant function in their home environment. Reassessments, if necessary may on occasion take place at the provider setting if it is determined that an assessment in the home is not an option.

In terms of timing, initial assessments, including eligibility determination, must be completed with participants within 30 calendar days of request for services unless client delay occurs. Reassessments must occur within 30 calendar days of participant request. Waiver service providers have a maximum of 15 calendar days to begin providing services to the participant from the date of the written notice of eligibility to the participant. These timeframes are maximums, and in most cases the process is completed much sooner. For those participants that are in imminent risk of being placed in a nursing home, care coordinators can request that participant’s receive interim services which require service providers to start services within 2 business days from the date of participant notice.

MCO Process:

The service plan is developed by the Plans’ care coordinators in collaboration with the waiver participant and/or their representative in following the same expectations as those set by the OA for the CCUs. Similarly, the MA has set the same expectations regarding the location of assessments and reassessments as stated above. Also, the timing of initial assessments and reassessments are the same.

b) Types of assessments conducted to support the service plan development process, including securing information about participant's needs, preferences and goals, and health status:
OA Process:

In (a) above, the process in all assessments is to have the participant articulate his/her needs, goals, and desires. Using this as a basis for a holistic approach to care coordination, the assessment of the participant’s situation and circumstances identifies all factors contributing to quality of life and the participant’s ability to live independently in the community. The CCP utilizes the Comprehensive Care Coordination (CCC) assessment tool for this holistic approach. The CCC tool includes a review of the participant's environment in the community, physical, cognitive, psychological, and social well-being. It also includes identification of existing support systems and the need for further evaluation(s) by other disciplines. The CCC tool covers eleven domains; participant demographics, physical health history, behavioral health, Determination of Need (DON) & Mini-Mental Status Exam (MMSE) evaluation, medications, nutrition, caregiver, transportation, environmental, financial and legal. Information collected in the CCC assessment is used to help the care coordinator and the participant form the POC. Risk factors, such as depression, alcohol and substance abuse, medications, caregivers, health, falls and behaviors, are identified and addressed throughout the domains of the CCC assessment tool. Care coordinators are trained to encourage the participant to direct the assessment as much as possible and to discuss potential risks and work together to develop a POC that will minimize or mitigate/eliminate the risk.

MCO Process:

The Plans have similar comprehensive assessment tools to the CCC that contain components that are used to elicit a wide-range of information from the participants and their representatives to support service plan development. These components in the assessments include, but are not limited to cognitive/emotional, ADLS, IADLS, behavioral health, medication, living supports, environmental conditions, and health care information. The Plans also review the Determination of Need, which identifies ADLs and IADS and need for care which is conducted by the OA. The assessment secures information including the member's strengths, needs, levels of functioning and risk factors. Through the assessment and care planning process the participant's goals and the strengths and barriers to achieving these goals are identified. Again, the MCOs similar to the CCUs are trained to look at the individual and approach the participant to direct the process.

The MCO contract specifies expectations for waiver clients, including content of and purposes for Enrollee Care Plans and HCBS Waiver service plans (for enrollees receiving HCBS Waiver services). As part of its work on behalf of HFS, the EQRO reviews assessments as part of its pre-implementation record review, onsite post-implementation record review as well as in quarterly record reviews to make sure the assessments meet contractual requirements.

c) Informing customer of services available under the waiver:

OA Process:

After the care coordinator determines eligibility and completes the CCC assessment, they discuss with the participant the array of services, regardless of funding sources, which are available to them and to what they are eligible. The array of services also includes the participant's goals that may not be met by a waiver or other formal service. It is the care coordinator's responsibility to explain all service options to the participant, including, but not limited to waiver services. Care coordinators are required to go through Case Management training that includes training on comprehensive care coordination. This training outlines services that are available through other state and federal agencies, local entities, and charitable organizations. IDOA utilizes local Area Agency on Aging (AAA) staff as co-trainers during these trainings to discuss available Older Adult Services (OAS) services and local resources in each area. The participants are required to sign the CCC assessment to ensure that it adequately represents their goals for care and that the care plan is designed as they want. Participants also sign a program consent form verifying that service options were explained to them and that they had freedom of choice in choosing their service and their service providers.

MCO Process:

The participant is informed by the Plan of the covered waiver services:
At the initial face-to-face visit by the case manager; in conjunction with the review of the member handbook/inserts
Annually when the Plan's case manager reviews the member handbook/inserts with the participant
In addition, the care coordinators are to encourage the participant to take the lead in plan development and to identify services that might not be included in the Plan, but reflect additional goals and desires of the participant. The Participant Centered Plan that emerges from this conversation is to reflect both Plan covered including waiver services and informal services.

d) Explanation of how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences:

OA Process:

The CCC assessment identifies unmet needs in 11 domains. The tool includes a summary section at the end of each domain that summarizes the needs identified by the care coordinator and participant during the assessment. These summary sections are then identified on the participant's goals of care and service plan. The Determination of Need (DON) assessment identifies level of need and unmet need for care. The DON assesses 15 areas including; eating, bathing, grooming, dressing, transferring, continence, managing money, telephoning, preparing meals, laundry, housework, outside the home, routine health, special health and being alone. Any unmet needs on the DON have to be addressed on the POC. Participant's preferences are obtained throughout the entire assessment process including during the development of the individualized and participant-centered service plans. Participants must sign the CCP consent form indicating that they were given a choice of services and a choice of provider agencies.

MCO Process:

Comprehensive assessments are developed by the MCOs. The MCO contract specifies expectations for waiver clients, including content of and purposes for Enrollee Care Plans and HCBS Waiver service plans (for enrollees receiving HCBS Waiver services).

After the comprehensive assessment has been completed by the MCO, and the array of services have been presented to and discussed with the participant, the Plan's case manager, the participant and/or their representative(s) formulate an individualized care plan that addresses their goals, strengths and barriers/risks in consideration of these goals, and the mutually agreed upon activities for achievement of these goals. The outcome is a Participant Centered Plan of Care. As this is participant-centric, personal preferences are integral to the development of the service plan, such as cultural preferences and provider preferences for language and gender. The service plan includes the type, amount, frequency, and duration of waiver services, and includes services and supports not covered under the waiver, all related to the needs and preferences expressed by the participant.
As part of its work on behalf of HFS, the EQRO reviews assessments as part of its pre-implementation record review, onsite post-implementation record review as well as in quarterly record reviews to make sure the assessments meet contractual requirements.

e) Explanation of how waiver and other services are coordinated:

OA Process:

The CCC is completed at the initial assessment and at least annually thereafter. This tool ensures that no duplication of services exists. The POC includes all other services the participant is receiving, regardless of funding source. The POC is then sent to each waiver provider on the POC so that the providers are aware of additional services or assistance in the home. Providers are trained to report any changes in the participant situation to the CCU including a disruption of other, non-waiver services. Identifying all agencies in the home on the POC assists the provider agencies to know who should be in the home and during what times, providing an additional level of quality assurance.

MCO Process:

Services are coordinated by the participant's assigned Plan case manager, who is responsible for the identification, authorization, and assignment to the responsible service provider in coordination with and direction from the participant and/or their representative.

f) Explanation of how the plan development process provides for the assignment of responsibilities to implement and monitor the plan:

OA Process:

IDOA mandates that upon initial assessment and every assessment thereafter, the care coordinator must provide the rights and responsibilities brochure to the participant. In addition, a Participant's Bill of Rights is to be added in WY 1 reflecting language that comports with Participant Centered Planning and rules related to settings. These brochures outline the responsibility of the participant and in regards to the Bill of Rights, those responsibilities of the MA and OA as it relates to receiving services. Included in these responsibilities of the participant is the responsibility to notify the care coordinator/CCU of any changes in their status, i.e., hospitalizations, changes in needs, changes in financial status, etc. The Department mandates that this brochure not only be given, but also explained and reviewed with the participant. Documentation in the participant's case record must support that this mandate was met. Provider agencies are also mandated to notify the care coordinator/CCU of changes in the participant's status. Department policies and training outline the responsibilities of the care coordinator. These responsibilities include development of the Participant-centered POC and continually monitoring of the service plans.

MCO Process:

The Plan case manager is responsible for the execution of the service plan, which includes monitoring the provision of waiver services and risk mitigation strategies. The participant's role is clearly defined in the care plan, and the

participant is responsible for actively participating and providing feedback. The Participant's Bill of Rights, as described above, will be added to the documents provided to participants receiving waiver services in WY 1.

g) Explanation of how and when the plan is updated, including when the participant's needs change:

OA Process:

Department administrative rules require that participants receive a new assessment at least annually if there is significant change and upon participant request, within 30 calendar days of participant request or within 15 days following discharge from a hospital or other institution. Participant's Plan of Care are reviewed and adjusted during each assessment. Participants can request a change to the POC at any time.

MCO Process:

For participants enrolled in an MCO, the Plan care coordinator is the lead for waiver service planning. The participant's service plan development begins with a comprehensive in-person assessment of the participant's health and supports, services needs, and their preferences and goals. Based on the outcome of the assessment, the care coordinator works with the participant to develop a service plan reflective of his/her goals, needs and choices. The participant's family and circle of support, if the participant so chooses, or his/her legal representative may be involved in every step of the assessment and planning process.

After each comprehensive assessment is completed, in which the member's current status and needs are identified; a new participant centered service plan is completed. During the assessment, and as needed in-between assessments, the Plan's case manager educates the participant to call the case manager to request a change in the plan if the participant's situation or needs change in-between assessments. The participant is educated to notify the case manager any time there is a change in their living or medical situation that may affect their need for services. Service plans can be created or adjusted in-between assessments to meet the member's immediate needs. Whenever there is a significant change in level of service needs or functioning (for example, hospitalization significantly impacting the participant's level of functioning), a new assessment is to be completed and additional services provided as needed.

The participant is in the center of the care/service planning process. The Plan case management staff completes a comprehensive assessment to identify the participant's strengths, needs, formal and informal supports based on information provided by the participant or representative. The participants have an active role in choosing the types of services and service providers to meet those needs. The case manager obtains the waiver participant's signature of agreement on the service plan and offers the waiver participant a choice of providers to fulfill the services
The Plan's case manager is responsible for providing clear direction to the participant regarding appeal rights whenever a reduction, termination, or suspension in service(s) occurs. The appeal rights are summarized in the service plan that the participant signs at the initial assessment, and each reassessment thereafter. If the member appeals, the services will remain intact until the appeal process is exhausted, including the State Fair Hearing. The member handbook/inserts that are provided to and reviewed with the participant also provide information on appeal rights and processes.

Timelines differ for completion of the health risk assessment for MCO enrollees only when a member becomes newly eligible for Elderly waiver services. A health risk screening is completed within 60 days of enrollment, and the more in-depth health risk assessment is completed within 90 days of enrollment. The assessment collects information about the member's physical, psychological, and social health.

- For members already receiving Elderly Waiver Services on their effective enrollment date with the health plan: the health-risk assessment must be face-to-face and completed within 90 days.
- For members receiving Elderly Waiver services and were enrolled in another health plan but transitioning to a new health plan: the health-risk assessment relating to those covered services must be face-to-face and completed within the first 90 days after the effective enrollment date.
- For members deemed newly eligible for Elderly Waiver Services: the health-risk assessment must be face-to-face and completed within 15 days after the health plan is notified that the member is determined eligible for Elderly waiver services.

All covered services start immediately - the day the member enrolls with the health plan. For members deemed newly eligible for Elderly Waiver Services, the health plan has 15 days to complete a health-risk assessment. The assessment must be face-to-face. Elderly waiver services then begin within those 15 days for the member.

For reassessments, health plans analyze reports and data on a monthly basis to identify risk level changes for their members. High risk members have care plans updated every 30 days and moderate risk members have care plans updated every 90 days. At a minimum, health plans shall conduct a health risk reassessment annually for every member with a care plan. All HCBS members, including Elderly Waiver members, have a care plan.

As a condition of approval for the Elderly waiver, a corrective action plan (CAP) addressing compliance with Person Centered Planning requirements in the Final Rule by requiring that the person centered plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for it implementation. In addition, providers responsible for the plan's implementation are given a written copy of the plan when it is developed and updated. The PCP CAP will be completed and fully implemented by December 31, 2018.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

As our care coordinators assess for participant needs, they are evaluating current participant risks and work with the participant to identify the resources and strategies to mitigate these risks through the linkage and delivery of services ultimately to prevent institutionalization and be successful in community residency. For example, if the participant is at nutritional risk, through the use of a home care worker or Older Americans Act funded home delivered meals may be part of the Participant Centered Plan of Care to mitigate this risk.

A significant strength in this waiver's approach to assessment is the CCC assessment tool which requires the care coordinator and participant to discuss a whole range of domains beyond those that waiver services may mitigate risk, but also may be issues that impact the success of the waiver service or any formal or informal support to mitigate the risk. Risk factors that could encompass such domains included in the CCC assessment tool, such as behavioral health of the participant including depression, anxiety and abuse of alcohol or other substances including illegal substances and medications; role of caregivers; physical health; occurrences and risks of falls are explored and addressed.

The CCC assessment develops with the inclusion of participant a comprehensive care plan. It also includes a back-up plan to the Participant Centered Plan of Care. The back-up arrangement is specific to the participant's needs and preferences. Care coordinators are trained that a back-up plan is not 911, but one that utilizes other formal social service agencies as well as family, neighbors and friends, and assistive technology devices. Together the Care Coordinator, participant and anyone else the participant elects to be engaged in the process discuss possibilities of both formal and informal options in the event that the services arranged for in the plan of care are not provided and establishes a back-up plan of care. The Care Coordinator assists the participant with posting the back up plan in a location that is accessible to the participant and other providers that support the participant. The back up plans include the names and phone numbers of persons and agencies who are available to immediately assist the participant if needed.

Additionally, per CCP rule [240.1510 q], provider agencies are responsible to have a policy for an all hazards disaster operations plan including but not limited to medical emergencies, home or site-related emergencies, participant-related emergencies, weather-related emergencies and vehicle/transportation emergencies. For example, in-home service agencies train their home care aides to make additional meals for storage and reheating during times of inclement weather just in case a home care aide cannot access a participant due to inclement weather.

MCO Process:

For participants enrolled in an MCO, the Plan care coordinator is the lead for waiver service planning. The assessment for potential risk is included in the service plan development process. The care coordinator at the MCO is expected to incorporate and utilize the same strategies as describe above in the development of the Participant Centered Plan of Care. Again, strategies to reduce, mitigate and eliminate risks must be identified. In addition, the care coordinator develops the backup plan and works with the participant to ensure necessary arrangements for back-up in-place.

The Plan's case manager completes a comprehensive assessment and care planning process for every participant. This process includes identification of the participant's cognitive/emotional functioning, behavioral health, medication, living supports, environmental conditions, ADLS, IADLS and health information. This process identifies risks that could encompass such domains as the behavioral health of the participant including depression, anxiety and the abuse of alcohol or other substances including illegal substances and medications; role of caregivers; physical health; occurrences and risks of falls. These are explored and addressed as they may increase and serve as barriers to the members' ability to live as safely and independently as possible. All risks are identified and discussed in the service planning process. Through service planning interventions, identified risk(s) are mitigated and barriers are addressed with interventions which are mutually agreed upon by the participant and the Plan.

Additionally, a backup plan is formulated for every participant who lives independently in the community and receives waiver services. The backup plan addresses the services currently in place, the urgency for receiving backup services should the current service be interrupted, and specific written instructions for addressing the gap. This includes names and telephone numbers of persons or agencies who are available to immediately assist in a backup arrangement. The list may consist of family, friends, community supports, or provider agencies.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from

among qualified providers of the waiver services in the service plan.

OA Process:

Care coordinators are notified of all certified contractual providers that provide services in their areas. The State requires that freedom of choice be afforded to every participant in the CCP. The care coordinators meet with the participants to discuss the goals of care, desires and develop the Participant Centered Plan of Care. It is the care coordinator's role to provide information about the available service providers to each participant and to answer any questions that arise. If the participant has no preference of a provider agency then the care coordinators are required to utilize a rotating service provider list. This list includes all service providers and is maintained at each local CCU office. Participants must sign a consent form that indicates that they were afforded freedom of choice or that they requested a provider agency be assigned to them from the rotation list. Information of available providers is available on the IDoA's website also for participants and their families to review. IDoA is committed to increasing the amount of information that is available via the Internet on service providers. Each service provider is also encouraged to have its own brochures and advertising material available upon participant or care coordinator request. Participants and families are encouraged to visit ADS providers before admission. Participants/authorized representatives identify the provider chosen and sign the Consent Form and Client Agreement to verify that the providers selected.

MCO Process:

For participants enrolled in an MCO, the Plan care coordinator is the lead for waiver service planning. The care coordinator assists the participant in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

It is the Plan’s care coordinator's role to provide information about the available services and service providers to each participant, and to answer any questions that arise. The Plan will assist the participant through the provider network supplying provider information relevant to the services selected by the member on their service plan and available in the member’s service area. Participants always have first choice on the providers they select to meet their needs. Plan care coordination staff supports the participant in selecting a provider to meet their needs if the participant does not have a preferred provider identified. The Plan maintains a current list of qualified and contracted service providers which are made available to participants upon request. The participant is also educated that the Plan’s provider list is available on the Plan’s website.

MCO Plans must have contracts in-place with a sufficient number of such Providers within each county in the Contracting Area to assure that the Affiliated Providers served at least eighty percent (80%) of the number of Participants in each county who were receiving such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) of such Providers, so long as such Providers accept Contractor’s rates, even if one (1) served more than eighty percent (80%) of the Participants, unless the Department grants Contractor an exception. It is the State’s goal that this will insure choice on behalf the member participant.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Service plans are subject to the approval of the MA. The OA and the MCOs have day-to-day responsibility for completion and approval of service plans; however, the MA, through its Quality Improvement System, reviews service plans through a sample process as described below.

The OA completes a Quality Improvement Review of each contracted CCP provider and Care Coordination Unit at least once every contract cycle of three years. This ongoing administrative activity allows the OA to ensure that providers and CCUs are adhering to the rules, regulations, policies, and procedures of the CCP. Prior to the review, the OA chooses a random stratified sample from the agency's billings in eCCPIS. The standard for determining the sample size is based on the number of participants served by the CCP provider per the agreement number. The sample includes both participants in the waiver program and participants covered by General Revenue funding. Prior to the review, the OA checks the SIP tracking database to review any complaints/concerns for each CCU and that participant's file is included in the sample.

For the OA, HFS reviews a sample of service plans when monitoring IDoA, the OA. During these reviews, plans of care are reviewed for compliance with state and federal regulations. Reports of findings are shared with IDoA and recommendations for improvement are made. The OA responds to the HFS reports both on an individual and systemic basis. Information is shared during quarterly meetings between HFS and IDoA.

For the MCOs, the MA selects a statistically valid sample for conducting onsite record reviews to assure compliance with federal assurances. The MA uses a proportionate sampling methodology with a 95% confidence level and a 5% margin of error for both the OA and the MCOs. The methodology will be adjusted when new MCOs are enrolled to ensure proportionate sampling across all operating entities.

Once the MA selects the sample, it is provided to the MA's External Quality Review Organization (EQRO), the entity responsible for monitoring the MCOs. The OA and the EQRO determine a review schedule, based on the sample and performs onsite record reviews to assess compliance with the service plan performance measures. For the MCOs, the EQRO sends a report of findings to the MA and the MCOs. The MCOs are required to remediate findings within required timelines, and report remediation activities to the MA, at least quarterly. The MCOs report on both individual and systemic remediation.
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Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☒ **Operating agency**
- ☒ **Case manager**
- ☒ **Other**

Specify:

For participants enrolled in an MCO, the Plan is responsible for maintenance of service plan forms.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The CCU/care coordinator is responsible for monitoring the implementation of the service plan and the participants health, safety and welfare.

a) Care coordinators and participants develop the POC together during the initial assessment and at each reassessment the POC is reviewed and adjusted as needed. Waiver participants are provided with the opportunity to lead the person cantered planning process.Department administrative rules require that participants receive a new assessment at least annually, when there is significant change, within 30 days of participant request and within 15 days of discharge from a hospital or institution.

The CCC assessment addresses all aspects of participant function and supports. The care coordinator identifies services needed and makes the appropriate referrals, as agreed upon by the participant and the care coordinator during the CCC care plan process. Referrals are made to a variety of services including those outside the services offered in the elderly waiver. Care Coordinators are trained to utilize local and regional funded services in addition to waiver services whenever appropriate. Examples of additional services include home delivered meals, medication management, flexible senior services, respite care, transportation, and medical and home health services.

b) The CCUs/care coordinators monitor the provision of services through participant contact, intensive case monitoring as applicable, and satisfaction surveys.

The participant, authorized representative, provider agency or care coordinator can request a follow-up by the care coordinator. When problems are detected, service plans can then be revised or new a service plan can be implemented. For those clients with complex care plans requiring more intensive follow-up to ensure that the additional referrals are in place and working properly, the program allows care coordinators to provide Intensive Case Work and Intensive Monitoring.

The CCC assessment triggers the need for more intensive case monitoring. For example, a participant that requires a complex care plan utilizing service providers both within the waiver and outside the waiver would be appropriate for Intensive Case Work. This allows the care coordinator to devote more time to making the appropriate referrals within the community and making sure that the participant has a complete care plan that will meet their needs. Intensive Monitoring is authorized for up to three months to allow the Care Coordinator time to ensure that the care plan is working and is meeting the participants needs.

c) Care coordinators are required to meet face to face with waiver participants at least annually, and more often as needed. Intensive monitoring is available for participants that require more frequent management.

It is the participant's responsibility to notify the CCU of any change in status or to request a change to the POC. Participants can request a change to the POC at any time. Provider agencies are mandated to notify the care coordinator or CCU of changes in the participants status. Department policies and training outline the responsibilities of the care coordinator, for development of the POC and continually monitoring of the service plans. Care coordinators can also authorize the Intensive Case work or Intensive monitoring for participants that require more frequent management. Intensive Monitoring requires a face-to-face meeting at least once in each month that it is billed.

For participants enrolled in an MCO, the Plan care coordinator is responsible for monitoring service plan implementation, including whether services and supports meet the participants needs and back up plans are adequate.

For the Plans, the primary avenue to monitoring the participant’s needs and service planning is the completion of the comprehensive assessments with the participant. The Plan case manager and the participant work collaboratively during the initial assessment and at each subsequent reassessment on the service plan process. The Plan case manager is responsible for monitoring the implementation of the service plan, the availability and effectiveness of identified services and supports, and the participant's overall health and welfare.

The care coordinator works with the participant to identify the agreed upon services to include in the service plan and coordinates the service delivery process based on the participant’s needs. Care coordinators also identify services, supports, or activity outside of the waiver benefit that may support the participant’s plan of care. In addition to being completed at the initial assessment and reassessment visits, the service plan is also reviewed in-between assessments if there is a change in service needs.

Service provision and participant satisfaction are continually monitored at each assessment. During each reassessment visit, the case manager reviews the service plan to ensure that services are furnished in accordance with the service plan and that the services provided by the service provider are meeting the needs of the participant. A new service plan will be created at each reassessment to capture members review and agreement with the service plan even if needs or services have not changed. The need for any additional non-waiver based services is also discussed. The case manager provides on-going education to the participant about reporting any issues with the provision of services and their service providers. The participants are encouraged to call the case manager to assist in resolving issues identified by the participant.

The case manager also reviews the backup plan to ensure it is still in effect and if the backup plan was utilized, it is discussed with the participant to ensure its effectiveness. The service plan, service providers, backup plan or referrals to non-waiver services may be made or modified to ensure the member's needs are adequately met based on these discussions.

The Plans have a process to implement a method of monitoring its case managers to include, but not be limited to conducting quarterly case file audits and quarterly reviews checking that service plans are completed with each assessment or in between assessments if members needs have changed, service listed on the service plan address members need identified in the assessment, back-up plans are created for members receiving in-home services and are comprehensive. The Plans have a process to compile reports of these monitoring activities to include an analysis of the data and a description of the continuous improvement strategies the case manager has taken to resolve identified issues. The Plans will provide the state the results of their discovery, remediation and any systems improvement activities during quarterly quality improvement meetings. Remediation will occur both on an individual and systemic basis.

Through its contract with the EQRO, the MA assures that the Plans are complying with contract requirements and the waiver assurances for monitoring service plans. Participants enrolled in the plan will be included in the overall representative sampling methodology used for evidentiary reporting of assurances. The Plans will be required to report event and other data to the MA where sampling methodology is 100%. MA oversight will include onsite or desk audit validation in these areas.

The MA selects a statistically valid sample for conducting onsite record reviews to assure compliance with federal assurances. The MA uses a proportionate sampling methodology with a 95% confidence level and a 5% margin of error for both the OA and the MCOs. The methodology will be adjusted when new MCOs are enrolled to ensure proportionate sampling across all operating entities.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
24D: # and % of OA and MCO participants' service plans that address all personal goals identified by the assessment. N: # of OA and MCO service plans reviewed that address all personal goals identified by the assessment. D: Total # of OA and MCO service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIO Record Review and OA Report; EQRO Record Review and MCO Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Margin of Error = 5%
☒ **Other** Specify: EQRO/MCO QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
25D: # and % of OA and MCO participants' service plans that address all participants needs identified by the assessment. N: # of OA and MCO service plans reviewed that address all participant needs identified by the assessment. D: Total # of OA and MCO service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIO Record Review and OA Report EQRO Record Review and MCO Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Margin of Error = 5%
☒ **Other** Specify: MCO QIO EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
26D: # and % of OA and MCO participants' service plans that address all health and safety risk factors identified in the assessment. N: #of OA and MCO service plans reviewed that address all participant health and safety risk factors identified in the assessment. D: Total # of OA and MCO service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIO Record Review and OA Report EQRO Record Review and MCO Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Margin of Error = 5%
☒ **Other** Specify: EQRO QIO MCO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
27D: # and % of OA and MCO survey respondents in the sample who reported they receive services when they need them. N: # of OA and MCO survey respondents in the sample who reported they receive services when they need them. D: # of OA and MCO survey respondents in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: POSM Survey questions A2

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports - POSM Survey questions A 2

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other**	☒ **Annually**	☐ **Stratified**

Specify: MCO		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
28D: # and % of service plans that were implemented pre-authorization by the OA and MCO with remediation within 60 days. N: # of service plans that were implemented pre-authorization by the OA and MCO with remediation within 60 days. D: Total # of service plans reviewed by the OA and MCO that were implemented pre-authorization.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: Reports to MA on delegated tasks. MCO Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
29D: # and % of OA and MCO participants' service plans that were signed and dated by the waiver participant and the case manager. N: # of OA and MCO service plans that were signed and dated by the waiver participant and the case manager. D: Total # of OA and MCO service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIO Record Review, OA Report, EQRO Record Review, MCO Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		95% confidence interval, Margin of Error 5%
☒ **Other** Specify: EQRO/MCO QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

30D: # and % of OA and MCO participants who received at least annual contact by their care coordinator in an effort to monitor service provision and to address potential gaps in service delivery. N: # of OA and MCO participants reviewed who received at least annual contact by their care coordinator. D: Total # of OA and MCO participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIO Record Review, OA Report, EQRO Record Review and MCO Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Margin of Error = 5%
☒ **Other** Specify: EQRO/MCO QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
31D: # and % of OA and MCO participants who have their Service Plan updated every 12 months. N: # of OA and MCO waiver participants reviewed who have their Service Plan updated every 12 months. D: Total # of OA and MCO waiver participants with service plans due during the period reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: eCCIPS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; EQRO Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☒ **Other** Specify: MCO/EQRO	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
32D: # and % of overdue Service Plan 12 month renewals that were remediated within 30 days by the OA and MCO. N: # of overdue Service Plan 12 months

renewals which were remediated within 30 days by the OA and MCO. D: Total # of OA and MCO overdue SErvice Plan 12 month renewals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA REports: REports to MA on delegated tasks, MCO reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
33D:# and % of OA and MCO waiver participants that received updates to service plans when participants needs changed. N:# of OA and MCO waiver participants reviewed that received updates to service plans when participants' needs changed. D: Total # of OA and MCO waiver participants identified whose needs changed."

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIO Record Review and OA Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Margin of Error = 5%
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

QIO		
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
EQRO Record Review, MCO Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Margin of Error = 5%
☒ **Other** Specify: EQRO MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
34D: # and % of OA and MCO participants who received services in the type, scope, amount, duration, and frequency as specified in the service plan. N: # of OA and MCO participants reviewed who received services as specified in the service plan. D: Total # of OA and MCO participants reviewed."

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIO Record Review, OA Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Margin of Error = 5%
☒ **Other** Specify: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports EQRO Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Margin of Error = 5%
☒ **Other** Specify: EQRO	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
35D:# and % of OA and MCO survey respondents in the sample who reported the receipt of all services listed in the plan of care. N:# of OA and MCO survey respondents who reported the receipt of all services listed in the plan of care. D: # of OA and MCO survey respondents in the sample."

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports - Satisfaction Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; CAHPS Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: CAHPS Guidelines
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
36D:# & % of OA participant records with latest CCP consent form & MCO participants POC indicating participant had choice between waiver services/instit care and between providers N:# of OA participant records with recent CCP consent form & MCO participants latest POC indicating participant had choice between waiver services/instit care and among svcs and providers D:Total # of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIO Record Review, OA Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Margin of Error = 5%
☒ **Other** Specify: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; EQRO Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		95% Margin of Error = 5%
☒ **Other** Specify: EQRO MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

24D: If plans do not address required items, the OA/MA will require the plans be corrected and the OA/MCO will provide training of case managers. Remediation must be completed within 60 days.

25D: If plans do not address required items, the OA/MA will require the plans be corrected and OA/MCO will provide training of case managers. Remediation must be completed within 60 days.

26D: If plans do not address required items, the OA/MA will require the plans be corrected and OA/MCO will provide training of case managers. Remediation must be completed within 60 days.

27D: If identifying information is available for individual surveys the OA and MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Patterns of negative responses, including anonymous survey responses, will be used to identify need for system improvement.

28D: The OA/MCO provides training to case managers and authorizes service plans if appropriate. If remediation not completed within 60 days, the OA/MCO reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

29D: If plans are not signed by appropriate parties, the OA/MA will require the plans be signed, with a review of the plan with the participant when indicated. The OA/MCO may also provide training in both cases. Remediation must be completed within 60 days.

30D: If participants do not receive at least annual contact by case manager, the OA/MA will require the participant be contacted and the OA/MCO will provide training of case managers. Remediation must be completed within 60 days.

31D: If service plans are untimely, the OA/MA will require completion of overdue service plans and justification from the case manager. If service plans are not updated when there is documentation that a participant's needs changed, the OA/MCO will require an update. In both cases the OA/MCO may require a plan of correction for case manager training. Remediation within 60 days.

32D: The OA/MCO conducts timely completion of the overdue Support Plans and renewals. The OA/MCO may also provide training for case managers. If remediation not completed within 30 days, the OA/MCO reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

33D: The OA/MCO will require that the plans be corrected, with full assessment if indicated. Remediation may include a plan of correction for care coordinator training. Remediation must be completed within 60 days.

34D: The OA//MCO will request the CCU/case manager to determine if there is a need for correction or adjustment of the service plan and services authorized. If not, services will be implemented as authorized, or require justification. The OA//MCO may require a plan of correction for case manager training. If the issue involves possible fraud, it will be reported by the OA/MA. Remediation must be completed within 60 days.

35D: If identifying information is available for individual surveys the OA and MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.

36D: The OA/MCO will assure that choice was provided as shown by the correction of documentation to indicate customer choice. The OA/MCO may also provide training to case managers. Remediation must be completed within 60 days.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Community Care Program/OA

Any individual who applies for or receives waiver services has the right to Appeal a decision, action or inaction of IDoA, a Case Coord. Unit (CCU) or a provider. The individual is notified by the CCU of his/her right to Appeal any time that action is taken regarding services or eligibility. In addition, the individual is given an explanation of the right to Appeal at the time of the initial home visit and upon request.

A copy of the rights and responsibilities of a CCP applicant/participant (including an explanation of the right to Appeal) is provided in written format to all individuals during the initial home visit for eligibility determination and upon request. Individuals can file an Appeal by contacting the Senior HelpLine or the CCU. They must complete and return to IDoA an official written "Notice of Appeal" form. IDoA then conducts an informal Appeal review within 60 days of receipt of the form. If the Appeal is denied at informal review and the individual does not submit a withdrawal,the Appeal automatically proceeds to a formal hearing.

Per 89 IAC 240.300, Applicant/Client Rights and Responsibilities, "The Department will assure that applicants/clients receive an explanation of their rights and responsibilities. A copy of the rights and responsibilities of a CCP applicant/client shall be provided in written format to all applicants/clients during the initial home visit for determination of eligibility or upon request by the applicant/client." The same information regarding the requirement to advise individuals of appeal rights is repeated in 89 IAC 240.400 Appeals and Fair Hearings, and in 89 IAC 240.910 Written Notification.

At each assessment, the Care Coord. is required to provide and review brochures, including a brochure regarding the participant's right to appeal. Participants receive written notice regarding the outcome of each assessment, which includes information regarding the participant's right to appeal as well as the process to do so.
Per 89 IAC 240.430, an informal review of the appeal is conducted by the Depart. and an Appeal Findings Notice with the outcome of that review is issued to the applicant. "If the appeal is denied, based upon the Dept. decision resulting from the informal review, the appeal shall automatically proceed to hearing unless the appellant/appellant's authorized rep. withdraws the hearing request in writing." This statement is included on the Informal Review Findings notication sent to the appellant/authorized representative.

Fair Hearing by MA

A hearing officer with HFS conducts the formal hearing. At the hearing, the individual is allowed to present evidence on his/her behalf to dispute the adverse action. The individual may choose to be represented by legal counsel or another person the individual appoints. The decision of the formal hearing is final and can only be Appealed through the circuit court system.

Participants who have filed an Appeal are notified that services will continue through the Appeal process via the IDOA Appeal action notice, which states that the level of service is being continued until the Appeal is complete. Fair hearing documents, including notices of adverse actions and requests for a Fair Hearing, are maintained by IDoA.

Advocacy

Beginning on 12/1/13, the IDoA LTC Ombudsman Program (LTCOP)expanded services to provide ombudsman services to individuals receiving managed care services, and who are living in community based settings. The LTCOP protects and promotes the rights and quality of life for people who reside in LTC facilities. The expansion of LTCOP services now makes ombudsman services available to home and community settings.
Program coverage includes seniors aged 60 and older, and disabled adults between the ages of 18-59. The target population includes beneficiaries of the Medicare/Medicaid Alignment Initiative, in addition to individuals receiving Medicaid waiver services. Participants in these programs have the option of ombudsman assistance when they Appeal a decision made on their case.

MCO

Participants enrolled in an MCO may file for an internal Appeal with the MCO and also have the right to request a fair hearing with final decision being made by the MA. The MA's fair hearings process is the same for all participants, including those enrolled with MCOs. The MA is the final level of Appeal.
MCOs are required to have a formally structured Appeal system that complies with Section 45 of the Managed Care Reform and Patient Rights Act and 42 C.F.R. 438 to handle all Appeals subject to the provisions of such sections of the Act and C.F.R. (including, without limitation, procedures to ensure expedited decision making when an Enrollee's health so necessitates and procedures allowing for an external indep. review of Appeals that are denied by the Plan). The State reviews/approves the

MCO's Appeal process guidelines.

MCO Internal Appeal Process

The Plans have a separate Appeal process that occurs prior to the Fair Hearing process. An Enrollee or an authorized representative with the Enrollees written consent may file for the internal Appeal or a Fair Hearing. MCOs are required to provide assistance to Enrollees in filing an internal Appeal or in accessing the fair hearing process including assistance in completing forms and completing other procedural steps. This includes providing interpreter services, translation assistance, assistance to the hearing impaired (including toll-free numbers that have adequate TTY/TTD) and assisting those with limited English proficiency. The MCO must make oral interpretation services available free of charge in all languages to all Enrollees who need assistance.

At the time of the initial decision by the MCO to deny a requested non-participating provider, deny a requested service or reduce, suspend or terminate a previously authorized service, a notice of action is provided by the MCOs in writing to the Enrollee and authorized representative, if applicable. In addition, the MCOs provide an Appeal resolution letter, which is also a notice of action, to the Enrollee at the time of the internal grievance or Appeal resolution. If the resolution is not wholly in favor of the Enrollee, the Enrollee may elect to request a fair hearing from the MA. The Appeal resolution letter includes the description of the process for requesting a Fair Hearing. If an Appeal is upheld by the Plan, the Plan sends an Appeal decision letter. This letter contains instructions on the Fair Hearing process.

Fair Hearing by MA

MCOs inform Enrollees about the participant/enrollee of his/her rights under the MA's Fair Hearing processes. These processes are defined in the member handbook distributed at the time of enrollment. Information about the fair hearing process is also on the MCOs website. The same information is provided whenever an Enrollee makes such a request. An Enrollee may appoint a guardian, caretaker relative, Primary Care Provider, Women's Health Care Provider, or other Physician treating the Enrollee to represent the Enrollee throughout the Appeal process.

The Plan informs the enrollee about their Appeal and fair hearing rights verbally and in writing at the initial face-to-face visit with the enrollee, at least annually, and as needed. Participants may Appeal if services are denied, reduced, suspended, or terminated. In addition, Appeals may be made any time the Plan takes an action to deny the service(s) of the enrollee’s choice or the provider(s) of their choice; The Appeal process is described in writing in the Plan’s member handbook which is reviewed with the participant by the Plan’s case manager.

When services are denied, reduced, suspended, terminated, or choice is denied, the member is informed via a Notice of Action Letter. This notice includes (a) A statement of what action the Plan intends to take; (b) The reasons for the intended action; (c) The guidelines or criteria used in making the decision.

The Notice of Action also contains information on appealing the determination and how services can continue during the period while the participant’s Appeal is under consideration. Participants who have filed an Appeal are notified that services will continue through the Appeal process via the IDOA Appeal action notice, which states that the level of service is being continued until the Appeal is complete.

All participants are provided a copy of their Rights to Appeal brochure at their initial assessment and every redetermination assessment. The brochure outlines the adverse actions that may be appealed and the process to request a Fair Hearing. Should a request for a Fair Hearing be requested, IDoA is notified via the Senior Helpline which logs calls through an Access database. The request for the Fair Hearing is sent via email to the Office of Home and Community Based Services where it is logged into Excel and tracked until the Formal Hearing date.

Reporting

Each MCO submits a qrtly. Grievance and Appeals summary report to the MA. The format of each report is dictated by the MA. This qrtly. summary report of Grievances and Appeals filed by Enrollees, is organized by categories of medical necessity reviews, access to care, quality of care, transportation, pharmacy, LTSS services and other issues. It includes the total grievance and Appeals per 1,000 Enrollees for their entire population enrolled in Man. Care. Additionally, it includes a summary count of any such Appeals received during the reporting period including those that go through Fair Hearings and external independ. reviews. These reports include Appeals outcomes- whether the Appeals were upheld or overturned. Appeals are reported separately for each Waiver. HFS reviews and analyzes the grievance and Appeals reports. HFS compares the reports among

plans over time and across plans to analyze trends, outliers among plans and to assure that the plans are addressing areas of concern. Records of adverse actions and requests for Appeals are maintained by the MCOs for a period of 6 years.

The State ensures that managed care enrollees, including those that receive waiver servies are informed by the MCO about their Fair Hearing Process by reviewing and prior approving the Enrollee Handbook, Notice of Action, and any Appeal letters which must contain the enrollees' rights to a Fair Hearing and how to request such. The States EQRO also reviews such documents through a desk review and determines if the MCO is compliant during on-site visits. The State reviews/approves the MCO's Appeal process guidelines. Copies of the Notice of Action documents, including notices of adverse actions and the opportunity to request a Fair Hearing, are maintained by the Plan in a database.

Fair Hearing by OA
Per 89 IAC 240.945, Notification, "any participant whose CCP services are being changed in the following manner shall be advised of the change by written notice: change of service type; reduced amount of service; increased monthly incurred expense prior to July 1, 2010; or termination. The written notice shall be sent to a participant/authorized representative by certified mail, return receipt requested, or given personally in which case the participant/authorized representative is to provide a signed dated receipt for the notice. In the event of death of a participant, regular mail is acceptable. The written notice on the Plan of Care Notification Form includes information regarding the participant's right to appeal as well as the process to do so.

Additionally, at each assessment, the Care Coord. is required to provide and review brochures, including a brochure regarding the participant's right to appeal. Documentation that the Care Coord. provided and explained the brochure is indicated by the participant/authorized representative's signature on the CCP Consent Form.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

IDoA operates the grievance and complaint system in cooperation with its contracted agencies. If participants file a grievance or complaint, they are informed that filing a grievance or complaint is not a prerequisite or substitute for a an Appeal and Fair Hearing. The OA's procedures do not require participants to file an informal grievance prior to exercising their right to appeal. An appeal can be requested by a participant/authorized representative for any action//inaction taken by a CCU, provider, or the OA. Under 89 III. Adm. Code 240.415 a list of these actions/inactions is outlined. A participant does not need to file a grievance before starting this process.

The Community Care Program also has a complaint and grievance process. At each assessment, the Care Coordinator is required to provide and review brochures, including a brochure titled, "Your Rights and Responsibilities." This brochure explains the OA's informal grievance process for participants/authorized representatives who are dissatisfied with some aspect of service provision. The Department's HelpLine Unit receives these calls and is trained to distinguish the difference between an informal grievance or complaint versus an appeal. If a participant or representative calls the hotline with what is actually an appeal, the participant's appeal rights are triggered.

For participants enrolled in an MCO, the Plans have established and maintain a procedure for reviewing Grievances registered by Enrollees.

Each MCO is required to establish and maintain a procedure for reviewing grievances (any expression of dissatisfaction about any matter other than an action) registered by Enrollees. All Grievances are registered initially with the MCO and may later be appealed to the MA through the Fair Hearing process. Enrollees must exhaust the MCO’s Grievance process before requesting a Fair Hearing.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Community Care Program/OA

Any participant or interested person may communicate a complaint through the State's Senior Helpline, a CCU, a care coordinator, or a provider. In addition, the Ombudsmen Program has been expanded for advocacy on behalf of participants enrolled in managed care. The State has defined complaints as any oral or written communication by the participant or other interested party expressing dissatisfaction with the eligibility, operation or provision of service (or lack therof), service quality, or service staff.

The information from a complaint is recorded as a CCP Event, using the Event Report Form. The data is placed into a statewide database. The lodged complaint is sent to the CCU in the area where the individual participant resides for investigation. The CCU is required to review the complaint and to resolve the issue within fourteen days, unless there are documented circumstances that preclude resolution within that timeframe. Mechanisms to resolve the complaint include the CCU working with the individual, their family, and provider agencies to address the problem.

In cases where the CCU is either the subject of the complaint or a complaint cannot be resolved, IDoA reviews the complaint. IDoA reviews the information and determines appropriate actions to be taken.

If the complaint involves a provider or CCU failure to meet expectations, IDoA has authority to issue a corrective action plan, to suspend new referrals, apply fines, cancel a contract, or take other appropriate action in accordance with 89 Ill. Adm. Code 240.1665.

Complaints are tracked in the Event reporting system. IDoA includes information about complaints in its quarterly management reports shared with HFS, CCUs, care coordinators, and provider agencies.

Managed Care Organization

For participants enrolled in an MCO, all grievances shall be registered initially with the Plan and may later be appealed to the MA. The Plan's procedures must: (i) be submitted to the MA in writing and approved in writing by the MA;(ii) provide for prompt resolution, and (iii) assure the participation of individuals with authority to require corrective action. The Plan must have a Grievance Committee for reviewing grievances registered by its enrollees, and enrollees must be represented on the Grievance Committee. At a minimum, the following elements must be included in the Grievance process:

- An internal informal system used to attempt to resolve all grievances;
- A Grievance system that has a formal structure compliant with Section 45 of the Managed Care Reform and Patient Rights Act and 42 C.F.R. Part 438 Subpart F to handle all Grievances subject to the provisions of such sections of the Act and regulations (including, without limitation, procedures to ensure expedited decision making when an Enrollee's health so necessitates);
- A Grievance system that has a formal structure that is available for Enrollees of the Plan when his/her Grievances cannot be handled informally and do meet the expectations of the procedures set-up under the Managed Care Reform and Patient Rights Act. All Enrollees must be informed that a Grievance system and its processes exist. Grievances that meet the expectations the Act, must be in writing and sent to the Grievance Committee for review;
- The composition of the Grievance Committee must include at least one (1) Plan enrollee on the Committee. The MA may require that one (1) member of the Grievance Committee be a representative of the MA;
- Final decisions under the Managed Care Reform and Patient Rights Act procedures and those of the Grievance Committee may be appealed by the enrollee filing the Grievance to the MA under its Fair Hearings system;
- A summary of all Grievances heard by the Grievance Committee and by independent external reviewers and the responses and disposition of those matters must be submitted to the MA quarterly; and
- An enrollee may appoint a guardian, caretaker relative, PCP, WHCP, or other Physician treating the enrollee to represent the Enrollee throughout the Grievance process.

The state has provided that individuals must first avail themselves of the internal Grievance and Appeals processes before accessing the Fair Hearings process. Enrollees are notified of these expectations through the Enrollee Handbook, the Notice of Action, and any Appeal letters. Plans also discuss the Grievance and Appeals process with the Enrollee during the service planning process.

Grievance means an expression of dissatisfaction about any matter. Grievances may include the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to

respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by health plans to make an authorization decision.
Health plans must have a formally structured Grievance and Appeal system that follows the Managed Care Reform and Patient Rights Act, and follows all Illinois and Federal laws subject to Grievances and Appeals as well.
Plans have policies and procedures in place for reviewing grievances submitted by the member or the member's authorized representative. Grievances can be submitted orally or in writing at any time.
HFS reviews the plans' grievance procedures, and approves them, verifying they provide for prompt resolution.
Health plans must acknowledge the receipt of a Grievance within 48 hours. Health plans must attempt to resolve all Grievances as soon as possible but no later than 90 days from receipt of a Grievance. Health plans have Grievance and Appeals committees that meet, at minimum, on a quarterly basis.

The Appeals system has some similarities, but the process for Appeals does differ from that of the Grievance system.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Illinois Department on Aging (IDoA) operates two critical event systems. For critical events that involve participant abuse, neglect and exploitation (ANE), there is an ANE reporting system under Adult Protective Services program. For other types of incidents there is a separate reporting process - Service Improvement Program (SIP). These other types of incidents do not meet the level of ANE. The SIP is currently functioning as the DOA critical event reporting system for non ANE reports while the refinements were made to the critical incident tracking database in eCCPIS. The refinements to the tracking database in eCCPIS were completed on 5/31/2016.

Any person can report a critical incident or make a complaint by contacting the State's Senior Helpline, a CCU, or a provider. Senior Helpline staff enters the critical incident report or complaint into the eCCPIS system and IDoA central office staff distributes the report to the designated CCU for follow-up. Central office staff track the necessary follow-up and enter the disposition to the incident into eCCPIS. Care coordinators are responsible for following up with the participant and/or their representative regarding the resolution to the incident or complaint. In general, participants/authorized representatives are notified of resolution of a critical incident b the CCU within 14 days of the resolution of the event.

IDoA plans to conduct statewide training for CCU on the policies surrounding reporting critical incidents, entering the reports directly into eCCPIS, risk mitigation strategies, and management of critical incidents. DoA is also working to ensure proper interfacing between the state's Adult Protective Service Program repairing system and the IDoA critical incident tracking system. (IDoA administers the Adult Protective Services Act).

Adult Protective Services

The processes defined under Adult Protective Services are the same whether the waiver participant receives care coordination through CCUs or through managed care.

Public Act 94-1064 amended the Elder Abuse and Neglect Act, changing the name of the entity to Adult Protective Services which had the effect of expanding the former elder abuse program to all adult populations. In addition, Adult Protective Services Act (320 ILCS 20/1 et seq.) authorized IDoA to administer the Adult Protective Services unit (APS) to respond to reports of abuse for all non-institutionalized adults. The empowered APS unit provides investigation of allegations and intervention and follow-up services to victims. It is coordinated through 42 agencies located throughout the state and designated by the Area Agencies on Aging (AAA) and IDoA. The contracts for this service and training are separate from IDoA contractual agreements for CCU care coordination services and CCP training. However, many of the CCUs are also designated APS agencies. The APS agencies conduct investigations of allegations of abuse and work adults, including those covered by the waiver in resolving abusive situations. Persons can report suspected abuse, neglect or exploitation to IDoA by utilizing the APS Hotline number at 1-866-800-1409, available 24 hours a day, seven days a week.

Definitions of ANE

The State uses a set of definitions for critical incidents covering abuse, neglect, exploitation and other events that can place an individual at risk. These definitions can be found at 89 ILAC Section 270.210.
The APS responds to the following types of abuse:

- Physical abuse means inflicting physical pain or injury upon an adult
- Sexual abuse means touching, fondling, intercourse, or any other sexual activity with an adult, when the adult is unable to understand, unwilling to consent, threatened or physically forced.
- Emotional abuse means verbal assaults, threats of maltreatment, harassment or intimidation.
- Confinement means restraining or isolating an adult, other than for medical reasons.
- Passive neglect means the caregiver’s failure to provide an adult with life’s necessities, including, but not limited to, food, clothing, shelter or medical care.
- Willful deprivation means deliberate denial of an adult medication, medical care, shelter, food, a therapeutic device, or other physical assistance and thereby exposing that person to the risk of physical, mental or emotional harm- except when the adult has expressed capacity to understand the consequences and intent to forego such care.
- Financial exploitation means the misuse or withholding of an adult’s resources by another to the disadvantage of the adult person, or for the profit or advantage of someone else.

Substantiated case means a reported case of alleged or suspected abuse, neglect, financial exploitation, or self-neglect in which a provider agency, after assessment, determines that there is reason to believe abuse, neglect, or financial exploitation has occurred.

Adult abuse refers to the following types of mistreatment to any Illinois resident age 18-59 living with a disability or an adult 60 years of age or older who lives in a domestic setting. The abuse must be one of the following types and must be committed by another person.

Abuse means physical, sexual or emotional maltreatment or willful confinement.
Neglect means the failure of a caregiver to provide an adult with the necessities of life, including, but not limited to food, clothing, shelter or medical care. Neglect may be either passive (non-malicious) or willful.
Financial exploitation means the misuse or withholding of an adult's resources by another to the disadvantage of the adult or the profit of another.

State regulations covering APS, mandated reporting, and timelines are contained in 89 Illinois Administrative Code (ILAC), Part 270. IDoA administers the Adult Protective Services Program, 320 ILCS 20/4. The statute requires mandated reporters to report abuse within 24 hours.

Mandated Reporters

The Illinois Adult Protective Services Act (320 ILCS 20/1) requires personnel of IDoA and its constituent AAA and provider agencies to be mandated reporters in cases where the adult is unable to self-report. IDoA policy specifically states that if a direct service worker witnesses or identifies a case of possible abuse or neglect, they are mandated to personally report the allegations to the designated APS agency or to IDoA's Hotline number. IDoAs Office of Adult Protective Services maintains a tracking system of ANE investigations and statistical reports are generated annually. Mandated Reporting and timelines for reporting can be found at: 89 ILAC, Section 270.230.

Elder Abuse Reporting

More information and brochures [Adult Protective Services Act and Related Laws and What Professionals Need to Know] may be found at: http://www.illinois.gov/aging/ProtectionAdvocacy/Pages/abuse.aspx

Reporting Timelines

Follow-up Actions by IDoA can be found at: 89 ILAC, Section 270.240 Intake of ANE Reports
Rules may be accessed at the OA's website at:
http://www.illinois.gov/aging/AboutUs/Pages/rules-main.aspx

Other Critical Incidents including those resulting in Death or Injury not related to ANE

For instances of alleged provider or CCU action/inaction leading to reported death or injury (but not due to suspected abuse or neglect), a verbal report must be submitted within twenty-four (24) hours to the Department, Division of Home and Community Services, Office of Community Care Services. The Provider or CCU must immediately follow-up on any such allegation and provide a written report to the IDoA's Division of Home and Community Services, within five (5) work days of the incident. When a participant death or injury resulting in the need for medical care occurs during the provision of CCP services, the Provider must notify the CCU and the Division of Home and Community Services within 5 work days of the incident. Upon notification from the Provider of an incident, the CCU investigates the circumstances by completing follow-up phone calls to the participant/authorized representative and any actions taken as a result of these conversations. The CCU must document these follow-up contacts and submit documentation to the Division of Home and Community Services within 10 work days of the incident. Upon receipt of injury and/or death reports from the Provider and CCU, Division of Home and Community Services staff will maintain follow-up communication with both agencies as long as pertinent activity either exists or is necessary.

Service Improvement Reporting (SIP)

When a Provider or CCU receives a complaint and/or problematic issue, they are to mutually attempt resolution. Complaints and/or problematic issues that are not able to be resolved may be documented on the Service Improvement Program Reporting Form (SIP) and faxed or mailed to the Department's Senior HelpLine within two (2) calendar days. SIPs are to be either resolved or a plan for resolution must be developed within fifteen (15) calendar days from the date of the SIP report. Both the CCU and provider agency must provide the Department with a completed SIP report/response

form within twenty (20) calendar days of the report to the Senior HelpLine. Department Division of Home and Community Services staff review SIP responses and may intervene to assure appropriate resolutions have occurred.

For participants enrolled in an MCO, the Plan are required to comply with all health, safety and welfare monitoring and reporting required by State or federal statute or regulation, or that is otherwise a condition for a HCBS Waiver, including, but not limited to, the following: critical incident reporting regarding Abuse, Neglect, and Exploitation; critical incident reporting regarding any incident that has the potential to place an Enrollee, or an Enrollee's services, at risk, but which does not rise to the level of Abuse, Neglect, or Exploitation; and performance measures relating to the areas of health, safety and welfare and required for operating and maintaining a HCBS Waiver. As such, the Plans comply with the Illinois Adult Protective Services Act (320 ILCS 20/1).

For critical incidents that are not defined as Abuse, Neglect and/or Exploitation, the Plans have internal processes that are not limited to, but include death, suspicious death, falls, serious physical injury, hospital admission, misuse of funds, Misuse of funds, medication error, unauthorized use of restraint, seclusion or restrictive physical or chemical restraints, elopement or missing person, fires, severe natural disaster, possession of firearms (participant or staff), possession of illegal substances (participant or staff), criminal victimization, financial exploitation, and suicide or attempted suicide.

For these types of incidents, if there is a perceived immediate threat to a member's life or safety, the Plan is to follow emergency procedures which may include calling 911.

All incidents are reported to the compliance officer or designee and entered in to the Plans Critical Incidents report database. Based on situation, the enrollee/members age and placement reports will also be made to the appropriate State of Illinois investigative agencies.

The Plans continues to provide participants, their family or representatives information about their rights and protections, including how they can safely report an event and receive the necessary intervention or support.

Also, the Plans assure that HCBS waiver agencies, providers and workers (including care coordinators) are well informed of their responsibilities to identify and report all critical incidents. These responsibilities are reinforced through periodic training.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Individuals and families are provided information from the CCU at the time of the initial assessment and annual rerassessment/redetermination on ANE and how to report other critical incidents. Training also covers the occurrence of assigned caregiver/workers not showing-up for service delivery. The State also requires the care coordinator to address with program participants issues of privacy, safety, and respect during administration of the State's consumer survey. This survey occurs during the assessment/reassessment process.

The need for general public awareness has been addressed through campaigns, "Break the Silence" and B*SAFE (Banks and Seniors Against Financial Exploitation). These public awareness campaigns, facilitated through APS, provide information and training about how to prevent and to recognize situations involving abuse, neglect, and exploitation of all adults including older adults.

Care coordinators receive training as part of the IDoA required training for all care coordinators on critical incident reporting and follow-up. Direct care staff is provided training through their employer and new state provider standards have enhanced requirements for staff training about abuse, neglect, exploitation, and mandated reporting requirements. As stated above, CCU and direct care staff are mandated reporters for abuse, neglect, and exploitation.
IDoA receives ANE through the APS hotline and other complaints and incidents through the Senior Helpline..
For participants enrolled in an MCO, the Plan trains all of its employees, Affiliated Providers, Affiliates and subcontractors to recognize potential concerns related to Abuse, Neglect and Exploitation, and on their responsibility to report suspected or alleged Abuse, Neglect and/or Exploitation. The Plan's employees who, in good faith, report suspicious or alleged Abuse or Neglect shall not be subjected to any adverse action from the Plan, its Affiliated Providers, Affiliates or subcontractors.

Providers, Enrollees and Enrollees' family members are trained about the signs of Abuse, Neglect and Exploitation, what to do if they suspect any of these actions to be taking place. In addition, they are informed of the Plan's responsibilities in regards to all critical incidents. Training sessions are customized to the target audience. Training includes general indicators of Abuse, Neglect and Exploitation and the timeframe requirements for reporting.

The Department developed a brochure for all Waiver participants and family members/guardians that explains how to report ANE. The Department amended its consent form to include documentation from the participant that they received a copy of the brochure. The new brochure and amended consent form went into effect in August, 2017.

Health plans must comply with all health, safety, and welfare monitoring and reporting required by State or federal statute or regulation, or that is a condition for a HCBS Waiver, including the following: critical-incident reporting regarding abuse, neglect, and exploitation; critical-incident reporting regarding any incident that has the potential to place a member, or a member's services, at risk, but which does not rise to the level of abuse, neglect, or exploitation; and performance measures relating to the areas of health, safety, and welfare and required for operating and maintaining an HCBS Waiver.
Health plans must comply with both the Elder Abuse and Neglect Act and the Critical Incident reporting requirements of IDoA.

Health plans must comply with HCBS Waiver reporting requirements to assure compliance with federal waiver assurances for health, safety, and welfare. Through an ongoing basis, the health plans must identify, address, and seek to prevent the occurrence of abuse, neglect, and exploitation. Performance Measures regarding health, safety, welfare, and critical-incident reporting are included in Table 2 to Attachment XI of the HFS contract.
Members are provided information about how and to whom to report abuse, neglect and exploitation during assessments and reassessments. For Elderly Waiver members, assessments happen quarterly during face-to-face meetings.

The health plan must train all of their external-facing employees on ANE and critical incidents. This includes network provider and subcontractors, who must be able to recognize potential concerns related to abuse, neglect, and exploitation. Health plans must also train those entities on their responsibility to report suspected or alleged abuse, neglect, or exploitation. Health plans train entities at outset on these subjects, can retrain when necessary, and post all material online for providers to review. Online material includes how to report ANE to appropriate authorities. Health plans train members, and family members about the signs of ANE and what to do if they suspect ANE. Training sessions are customized to the target audience. Trainings include general indicators of ANE and the time-frame requirements for reporting suspected ANE.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives

reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The automated critical event reporting system was implemented in July, 2017. The Department conducted twelve regional trainings on the new reporting system, including the expanded definitions of critical events, the requirements for reporting and follow-up, and the requirements for coordination between the Adult Protective Service system and the HCBS Waiver system.
Participants, family members and others may call the State's Senior Helpline: 1-800-252-8966 or the 24-Hour Adult Protective Services Hotline: 1-866-800-1409. APS
IDoA, the CCU and the care coordinator are notified of incidents in all cases. Depending on the nature of the incident of Abuse and Neglect and Exploitation (ANE), the participant and/or family members, and providers may be notified. The State has set criteria regarding when notifications are mandatory or are at the discretion of the care coordinator.

IDoA has established classifications for critical incidents (i.e., Priority I, II, III,) depending upon the nature and urgency of the event. This classification determines whether an investigation needs to occur in the timeframe for conducting that investigation. The definitions and time frames of these levels are located at 89 ILAC Section 270.240
Responding to Reports –
Depending on the nature and seriousness of the allegations, a trained caseworker makes a face-to-face contact with the alleged victim with the following time frames:

•Priority One – Reports of abuse or neglect where the alleged victim is reported to be in imminent danger of death or serious physical harm. The caseworker must make a face-to-face visit within 24 hours.

•Priority Two – Reports that an alleged victim is being abused, neglected, or financially exploited and the report taker has reason to believe that the health and safety consequences to the alleged victim are less serious that priority one reports. The caseworker must make a face-to-face visit within 72 hours.

•Priority Three – Reports that an alleged victim is being emotionally abused or the alleged victim's financial resources are being misused or withheld and the report taker has reason to believe that there is no immediate or serious threat of harm to the alleged victim. The caseworker must make a face-to-face visit within 7 calendar days of the receipt of the report.

The State requires that all Priority I incidents be at least temporarily corrected within 24 hours and a permanent correction must occur within 60 days. All other events must be corrected within 60 days. The State's Office of Adult Protective Services' regulations also require certain response timelines by the ANE agency. These are located at 89 ILAC Part 270.

The Event Reporting system also tracks the status of any investigation and follow-up actions taken. The State has established criteria regarding when the CCU must conduct a review, when an on-site visit must occur, and when the change of status assessment must occur.

The CCU is responsible to ensure the health and welfare of the participant and may authorize additional services, such as intensive care coordination, to protect the welfare of the individual. Critical incidents may also result in a review of participant needs to determine whether a change in the service or level of service is needed.

APS Reporting

State requirements for reporting of abuse, neglect or financial exploitation of participants' age 60 years and older are as follows:

The Illinois Department on Aging (ID0A) Office of Adult Protective Services administers the Abuse, Neglect and Financial Exploitation Program (ANE), which responds to alleged abuse, neglect or financial exploitation of persons 60 years of age and older who reside in the community. The program provides investigation, intervention and follow-up services to victims. It is locally coordinated through 42 agencies designated by the Area Agencies on Aging (AAA) and IDoA. The Adult Protective Services Agencies conduct investigations and work with older adults in resolving abusive situations.

Abuse Hotline Number:

866-800-1409 (voice): available 24 hours a day, seven days a week

888-206-1327 (TTY)

Other Critical Incidents – Deaths or Injury not related to ANE

For instances of alleged provider or CCU action/inaction leading to reported death or injury (but not due to suspected abuse or neglect), a verbal report must be submitted within twenty-four (24) hours to the Department, Division of Home and Community Services, Office of Community Care Services. The Provider or CCU must immediately follow-up on any such allegation and provide a written report to the Division of Home and Community Services, within five (5) work days of the incident. When a participant death or injury resulting in the need for medical care occurs during the provision of CCP services, the Provider must notify the CCU and the Division of Home and Community Services within 5 work days of the incident. Upon notification from the Provider of an incident, the CCU must complete follow-up phone calls to the participant/authorized representative. The CCU must document these follow-up contacts and submit documentation to the Division of Home and Community Services within 10 work days of the incident. Upon receipt of injury and/or death reports from the Provider and CCU, Division of Home and Community Services staff will maintain follow-up communication with both agencies as long as pertinent activity either exists or is required.

Service Improvement Reporting (SIP)

When a Provider or CCU receives a complaint and/or problematic issue, they are to mutually attempt resolution. Complaints and/or problematic issues that are not able to be resolved may be documented on the Service Improvement Program Reporting Form (SIP) and faxed or mailed to the Department's Senior HelpLine within two (2) calendar days. SIPs are to be either resolved or a plan for resolution must be developed within fifteen (15) calendar days from the date of the SIP report. Both the CCU and provider agency must provide the Department with a completed SIP report/response form within twenty (20) calendar days of the report to the Senior HelpLine. Department Division of Home and Community Services staff review SIP responses to assure appropriate resolutions have occurred.

For participants enrolled in an MCO, the Plans have similar processes and procedures in place to receive reports of critical incidents. Critical events and incidents must be reported and identified issues routed to the appropriate department within the Plan and when indicated to the investigating authority described above. The procedures include processes for ensuring participant safety while the State authority conducts its investigation.

Health plans must comply with Critical Incident reporting requirements found in the Elderly Waiver for incidents and events that do not rise to the level of abuse, neglect, or exploitation. Health plans have processes and procedures in place to receive reports, monitor, and track and resolve Critical Incidents. Critical events and incidents must be reported, and issues that are identified must be routed to the appropriate department within the health plan's organization and, when required or otherwise appropriate, to the investigating authority. All investigating authorities and their contact information is listed in the HFS/health plan contract.
Health plans maintain an internal reporting system for tracking the reporting and responding to Critical Incidents, and for analyzing the event to determine whether individual or systemic changes are needed. Health plans must comply with decision made by the investigating authority. For example, when the Adult Protective Services authority provide the health plan with a complete report of substantiation decision plans have 15 days to make suggested changes and respond to the finding.

The participant who is the subject of a report to Adult Protective Services (APS) or (participant's family member, or legal representative) is informed about the results of the investigation within 60 days of the date the report is received. Notification is documented in the participant's case record. The APS Program supervisor signs off on the record entry. Compliance with this requirement is reviewed annually as a measurement of case quality. When a case is not substantiated, the participant or (participant's family member, or legal representative) is informed by the method most appropriate to assure the participant's confidentiality. For cases that are substantiated, the same confidentiality considerations are applied, but notice of the investigation results is most generally incorporated in the face-to-face visit with the participant when a substantiated risk assessment is completed and a case plan is discussed with the participant that focuses on interventions to mitigate risk.

The critical event policy requires the Adult Protective Services Provider Agency (APSPA) to notify the Care Coordination Unit (CCU) and the Department's Office of Community Care Services (OCCS) of all substantiation decisions within two business days from the date of substantiation. Additionally, the APSPA is required to notify the Managed Care Organization (MCOs) of the report of the substantiation decision via email within two business days from

the date of substantiation.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The OA, IDoA oversees the reporting and response of all critical incidents and complaints. IDoA is in the process of developing a CCP Event Report system in order to analyse trends and ensure that follow up has occurred.IDoA reviews information about all critical event reports and activities at least quarterly. For some individual circumstances, the IDoA may be working with ANE or the CCU to resolve the issue.

The centralized web-based system for reporting, tracking and following up on Critical Events was implemented on July 12, 2017. Reportable Critical Event definitions, reporting procedures, times frames for reporting and follow-up are outlined in the Critical Event Policy dated July 7, 2017. Data will be used to inform IDoA and HFS to monitor system performance and remediate problems. CCUs and care coordinators will receive information in their quarterly performance reports about critical events involving CCP recipients for whom they are responsible. IDoA and the CCUs also review statewide and regional performance at quarterly meetings.

For participants enrolled in an MCO, the Plans maintain an internal reporting system for tracking the reporting and response to critical incidents, and analysis of the event to determine whether individual or systemic changes are needed. Critical incident reporting is included in the reporting requirements to the MA. The MA monitors both compliance of performance measures and timeliness of remediation for those waiver participants enrolled in an MCO. Participants in MCOs are included in the representative sampling.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

IDoA and CCU agencies are responsible for detecting the unauthorized use of restrictive interventions. Their oversight includes:

1.CCU and care coordinator reviews of all CCP Event Reports involving the use of restrictive interventions.

2.IDoA will review instances of restrictive interventions reported through event reports that are outside the restraint and seclusion policy.

3.During Quality Improvement reviews, IDoA will review documentation of instances of restraint and seclusion to verify that restrictive interventions were not used.

For participants enrolled in an MCO, the Plans are responsible to detect the unauthorized use of restrictive interventions. Events involving the use of restrictive interventions are reported to the Plan as a reportable incident, and reported to the investigating authority as indicated.

The MCOs and OA are to detect unauthorized use of restraints and/or seclusion through face-to-face visits, routine contacts with the participants, and through complaint or incident reporting. The case coordinators are responsible for the overseeing the waiver participants and assuring their health, safety, and welfare.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

IDoA and CCU agencies are responsible for detecting the unauthorized use of restrictive interventions. Their oversight includes:

1.CCU and care coordinator reviews of all CCP Event Reports involving the use of restrictive interventions.

2.IDoA will review instances of restrictive interventions reported through event reports that are outside the restraint and seclusion policy.

3.During Quality Improvement reviews, IDoA will review documentation of instances of restraint and seclusion to verify that restrictive interventions were not used.

For participants enrolled in an MCO, the Plans are responsible to detect the unauthorized use of restrictive interventions. Events involving the use of restrictive interventions would be reported to the Plan as a reportable incident, and reported to the investigating authority as indicated.

The MCOs and OA will detect unauthorized use of restraints and/or seclusion through face-to-face visits, routine contacts with the participants, and possibly through complaint or incident reporting. The case managers will be responsible for the overseeing the waiver participants and assuring their health, safety, and welfare.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including

restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Care coordinators through their regular contact monitor for all activities that appear to fall under abuse, neglect and exploitation. Seclusion would fall under this category. In addition, all providers are trained to monitor similar activities. Reports of abuse, neglect and exploitation, including seclusion are to be made to the Adult Protective Services Unit for investigation.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed

living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- (●) **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ( ) **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ( ) **Not applicable.** *(do not complete the remaining items)*
- ( ) **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- ( ) **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
37G:#and% of participants who received information from the OA and MCO about how and to whom to report A/N/E at the time of assessment/reassessment. N:#ofparticipant records reviewed where the participant received info from the OA and MCO about how and to whom to report abuse, neglect exploitation at the time of assessment/reassessment. D:Total#of OA and MCO participant records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIO Record Review OA Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence, Margin of error = 5%
☒ **Other** Specify: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
EQRO Record Review MCO Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence, error rate of 5%
☒ **Other** Specify: EQRO MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
38G:#and%of participants' substantiated incidents of abuse, neglect or exploitation that were reported to the OA and investigated by the OA within 30 days. N:#of participants' substantiated incidents of A/N/E that were investigated within 30 days. D:Total#of substantiated incidents of abuse, neglect or exploitation reported to the OA."

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
39G: # and % of participants' substantiated cases of abuse, neglect or exploitation where the OA and MCO implemented the OA (APS) recommendations. N: # of substantiated cases of abuse, neglect or exploitation where case is closed based on reduction in risk score (per review every 90 days). D: Total # of substantiated cases of abuse, neglect or exploitation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid**	☐ **Weekly**	☒ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
40G: # and % of participants' deaths as a result of substantiated case of abuse, neglect or exploitation where appropriate follow-up actions were implemented by the OA (APS). N:# of deaths as a result of a substantiated case of A/N/E where appropriate follow-up actions were implemented by the OA (APS). D:Total # of deaths as a result of a substantiated case of A/N/E.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
41G:#&% of participants for whom identified critical incidents other than ANE were reviewed & corrective measures were appropriately taken by OA & MCO. N:#of participants for whom identified critical incidents other than ANE were reviewed & corrective measures were appropriately taken by OA &MCO. D:Total#of OA & MCO participants for whom identified critical incidents other than ANE were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports MCO Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
42G: # and % of restraint, or other restrictive intervention, where appropriate intervention by the OA and MCO occurred. N:# of restraint or other restrictive interventions where appropriate intervention by the OA and MCO occurred. D:Total # of OA and MCO restraint applications or other restrictive interventions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
43G: # and % of seclusion interventions where appropriate intervention by the OA and MCO occurred. N: # of seclusion interventions where appropriate intervention by the OA and MCO occurred. D: Total # of OA and MCO seclusion interventions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
44G: # and % of participant survey respondents who reported to the OA and MCO of being treated well by direct support staff. N: # of participant survey respondents who reported to the OA and MCO of being treated well by direct support staff. D: Total # of OA and MCO participant survey respondents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: QA Satisfaction Surveys; POSM Survey question E.1.a. MCO Reports: POSM Survey question E.1.a.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
45G: # and % of OA and MCO in-home service providers who have policy addressing participant back up plans. N: # of OA and MCO in-home service providers who have policy addressing participant back up plans. D: Total OA and MCO in-home service providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIO Record Review, OA Report, EQRO Record, MCO Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence, Margin of error = 5%
☒ **Other** Specify: QIO EQRO MCO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

IDoA has a three-prong approach to address health, safety and welfare issues.

First, the state obtains a direct report of potential issues affecting health and safety from the participants. For individual waiver participants, the care coordinator completes an initial and annual assessment to determine needs of the participant (see Service Planning). This process includes using the DON to identify unmet needs and administering the POSM, a participant survey tool. Some of the POSM questions pertain to the individual's perceptions of safety, privacy, and respectful treatment. The care coordinator addresses problems identified during the assessment process or survey administration either as a service planning issue or a CCP event report. IDoA tracks information from the assessment and event reports through its eCCPIS and CCP Event Report systems. Care coordinators are required to follow-up with any participants reporting that they did not feel safe, that their privacy is not respected, or they are not treated with respect. Care coordinators supervisors monitor the care coordinators performance in these areas. IDoA also monitors the performance of the CCUs.

Second, the state's approach screens-out individuals with criminal backgrounds who seek employment with providers. Provider staff, in addition to meeting educational and training requirements for a job, must undergo a background check as part of the conditions of employment. Providers are responsible to complete the background check, maintain information in the employee file, and enter verification in the training tracking database. IDoA audits for compliance with this requirement when completing quarterly management reports, during the provider audit, and the documentation is verified during the onsite reviews.

Finally, the approach maintains a system to intervene and remediate reported incidents and complaints. IDoA maintains a CCP Event Report system to deal with critical incidents or complaints involving CCP participants. A critical incident includes a range of defined events that negatively impact the health and welfare of a waiver participant. These events are classified within one of four levels of intensity, depending on the nature of the incident and the level of risk posed. A complaint includes any oral or written communication by the participant or other interested party expressing dissatisfaction with the operation or provision of service, service quality, service staff, or a failure to provide/offer services.

Any person can report a critical incident or make a complaint by contacting the state's Senior Helpline, a CCU, or a provider. The state uses a CCP Event system to record information. The Senior Helpline can enter data. After a CCP event is reported, the CCU receives notice and is responsible to review each incident or complaint. If the report includes suspected abuse, neglect, or exploitation, the state's Adult Protective Service (APS) agency is immediately notified so that it may begin its investigation as required by Illinois Elder Rights regulations.
The state has developed a protocol to deal with CCP reports of critical incidents and complaints. The protocol defines timelines, notification requirements, referrals, and follow up steps. All critical incidents and complaints must be resolved within State set timelines, unless there are documented circumstances that preclude a resolution within this timeline. If resolution is not immediately forthcoming, the CCU is responsible to continue to ensure the health and welfare of the individual during this time.
The Medicaid agency, HFS, conducts routine programmatic and fiscal monitoring for both the OA and the MCOs.

For those functions delegated to the OA and the MCOs, the MA is responsible for oversight and monitoring to assure compliance with federal assurances and performance measures. The MA monitors both compliance levels and timeliness of remediation by the OA and MCOs.

The MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the OA and the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The MA pulls the sample annually and adjust the methodology as additional MCOs are enrolled to provide long term services and supports. For critical incidents, the MCOs are required to report 100% of the findings and remediation. These reports are summarized by the Plans and reported at least quarterly to the MA.

For the OA, reviews include compliance with employee background checks. Prior to and during onsite provider reviews, HFS reviews related critical event reports.

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit

quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in HFS' contracts with Integrated Care Program MCOs that provide waiver services. Contracts specify numerators, denominators, sampling approaches, data sources, etc. Through its contract with the EQRO, the MA monitors both compliance of PMs and timeliness of remediation for those waiver participants enrolled in an MCO through consumer surveys and quarterly record reviews. Participants in MCOs are included in the representative sampling.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

37G: The OA/MCO will require a plan of correction from the CCU/case manager to include providing the information to and reviewing it with the participant. Documentation will be made in the record. Remediation must be completed within 30 days.

38G: The OA /MA will require a plan of correction from the CCU/case manager or provider agency when incidents are not reported and acted on in accordance with policy and required timelines. Changes in participants' service plans will be made when indicated and individual safety will be first priority. The OA/MCO will follow up all outstanding Unusual Incident Reports. Remediation must be completed within 30 days.

39G: The OA/MCO will implement the Adult Protective Services (APS) recommendations for substantiated cases of abuse, neglect or exploitation. Changes in customers' service plans will be made when needed. Remediation must be completed within 30 days.

40G: The cause of death and circumstances surrounding it would be reviewed by the OA. The MA will require a plan of action from the OA that may include training, plan of correction or other remediation, based on circumstances and identified trends and patterns, up to and including sanctions or provider termination.

41G: The OA and MCO will follow up on identified critical incidents, other than A/N/E, to ensure information was reviewed and corrective measures were appropriately taken. Resolution or remediation will be based on the nature of the concern.

42G: Reports of incidents involving restraint interventions or other restrictive interventions will be reviewed by the OA and MCO. The OA or MCO will first ensure the participant's safety and wellbeing, and referral for investigation as indicated. Based on the investigation, remediation may involve training, revision to the plan of care, sanctions, or provider termination. Systemic changes would be based on identified trends and patterns.

43G: Reports of incidents involving seclusion will be reviewed by the OA and MCO. The OA or MCO will first ensure the participant’s safety and wellbeing, and referral for investigation as indicated. Based on the investigation, remediation may involve training, revision to the plan of care, sanctions, or provider termination. Systemic changes would be based on identified trends and patterns.

44G: If identifying information is available for individual surveys the OA and MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Patterns of negative responses, including anonymous survey responses, will be used to identify need for system improvement.

45G: The OA and MCO would require a plan of correction from the CCU/case manager to include participant's service plan revisions addressing the backup plan. The plan may require case manager training. Timeline for remediation would be within 30 days.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: MCO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency (MA), and the Illinois Department on Aging, as the Operating Agency (OA), and the contracted Managed Care Organizations (MCOs) work in partnership to evaluate the waiver Quality Management System (QMS). This partnership provides analysis to information derived from discovery and collaboratively develops and monitors remediation activities for each of the federal assurances.

For the OA, the IDoA and HFS management reports track changes in performance measures over time. This includes tracking changes across the entire state as well as by region and provider type. This helps to identify problematic areas and potential best practices. IDoA aggregates information and generates these reports on a quarterly basis.
For the OA, the state takes a multi-phased and multilevel approach to using management reports to improve the overall system. Because changes in the performance indicator may be explained by an external factor that would not require remediation (e.g., better targeting of individuals with greater impairment than may have an adverse impact on some of the performance indicators), the first step is to investigate to try to determine if an actual problem exists. The second step is to formulate potential interventions that may remediate the problem. The third step is to roll out those interventions, possibly on a pilot basis. The final step is to track changes using the original performance indicators to assess the impact of intervention.

Because the state's system between HFS and the OA is hierarchical. HFS oversees IDoA, which oversees the individual CCUs, which oversee the individual care coordinators, the process described above must be multilevel. Consequently, the state's quality management system includes regular and structured oversight meetings to facilitate communication, investigation, and problem solving across the levels. Each CCU is required to have at least monthly quality management meetings with their individual care coordinators. IDoA is meeting with the CCUs as a whole on a quarterly basis, as well as, reviewing the performance of individual CCUs on a quarterly basis and meeting with them on at least an annual basis (and more often if performance is problematic). IDoA and HFS meet on at least a quarterly basis.

The OA and MCO’s are responsible for the majority of the data collection to address the Quality Management System discovery and remediation activities. The OA is solely responsible for eligibility and authorizing qualified providers. Therefore, there are distinct performance measures for these functions under the OA. Both the OA and the MCOs are accountable for all other measures. The MA is accountable for the measures in the Administrative Authority appendix. Additional measures have been added under the Administrative Authority appendix that is specific to oversight of the MCOs. The state's system improvement activities are in response to aggregated and analyzed discovery and remediation data collected on each of the waiver performance measures.

On a quarterly basis, the MA conducts separate Quality Management Committee (QMC) meetings with the OA and the MCOs to review data collected from the previous quarter and for the year to date. Data is collected on a regular basis and is reported as indicated by the performance measure in the waiver. All reports will be provided to MA for review prior to the quarterly meetings. Annual reports are produced identifying trends based on the representative sample and/or 100% review of data.

Data will be reported by individual performance measures. Data reported includes: level of compliance and timeliness of remediation based on immediate, 30, 60, 90 day increments and any outstanding remediation. The MCOs may report in a slightly different format than the OA as there are additional performance measures.

During quarterly meetings, the MA and the OA or MCO identify trends based on scope, severity, changes and patterns of compliance by reviewing both the levels of compliance with the performance measures and remediation activities conducted by the OA and the MCOs. Identified trends are discussed and analyzed regarding cause, contributing factors and opportunities for system improvement. Systems improvement is prioritized based on the overall impact to the participants and the program. Systems improvements may be prioritized based on factors such as: the impact on the health and welfare of waiver participants, legislative considerations and fiscal considerations. The OA and the MCOs maintains separate QMC Systems Improvement Logs. Recommendations for system improvements are added to the log(s) for tracking purposes. The OA and the MCOs documents the systems improvement implementation activities on its respective log. The MA assures that the recommendations are followed through to completion. Decisions and time lines for system improvement are based on consensus of priority and specific steps needed to accomplish change. These decisions are documented on the systems improvement log and communicated through the sharing of the quarterly meeting summary and the systems

improvement log.

HFS hosts weekly operational meetings. All Managed Care companies are required to attend. Subject matter is based on MCO need and/or HFS identified need. These meetings are titled "educational series".

The Department shares the following data points with the Care Coordination Units on a monthly basis: compliance with annual redeterminations; compliance with completions of the Participant Outcome Status Measure Survey (POSM); and compliance with critical incident follow up reports. The data is aggregated by contract number. Every quarter, the Department shares the average scores of the POSM surveys. Every 6 months, the Department shares the DON Utilization summarized by contract number. Every year, the Department shares the results of the participant satisfaction survey with each of the provider groups. All of these are shared with the Care Coordination Units. Additionally, the Department shares the results of the annual participant satisfaction survey with the Departments Advisory groups and specific provider groups that the survey pertains to, e.g. in home providers. All of the data that is shared with the provider network is also shared with HFS at the Waiver quarterly meetings.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☒ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

For the OA, the state use the same mechanisms that it uses to identify potential issues including contract compliance, satisfaction surveys, assurances, critical incidents and SIPs to monitor the effectiveness of any and all interventions. The state tracks changes in the performance indicators using data analysis and generation of reports.

In the OA section above, the roles of the Medicaid agency (MA), IDoA (OA), the individual CCUs, and the care coordinators are described. For both the OA and MCOs, participant input also plays a central role in the quality management system as follows: 1) Participants perception of the quality of their services using constructs that are meaningful to participants (e.g., integration in the community, dignity, respect, etc.) as gathered through the POSM are used as a central performance indicators. This provides IDoA and the MCOs with the direct feedback loop about the effect of potential interventions on the quality of life for individual participants; and 2) care coordinators share reports with participants and their representatives about how their experience compares to that of other consumers across the state.

As an example, IDoA, the MCOs and HFS monitors trends in participants reports of opportunities for community integration using data gathered from the POSM. The entities may notice a pattern of low scores for certain providers, but high scores for others. This will lead IDoA to query the individual care coordinators about provider practices that may explain this discrepancy. The entities will subsequently use best practices that are identified as a core component of training, in the training of poor performers. IDoA may even collaborate and utilize providers who appear to be performing well on this training. IDoA subsequently tracks the performance of providers who receive this training to assess the efficacy of the intervention.

In the OA waiver quality plan, the State has implemented additional efforts to address its ability to improve and maintain quality. These include:
1) Updated performance measures in each of the waiver areas,
2) Redesigned reports to be used on a quarterly basis,
3) Updated CCP Event Report system and clearer delineation of critical incident definitions and follow-up procedures including training for CCUs on reporting and management of critical events.
4) Implementation of training tracking system and a new case note system, and
5) Implementation of two participant survey processes, both of which have been tested for validity and reliability.

IDoA meets with the Community Care Program Advisory Committee (CCPAC) six times a year to present information about the waiver and receive input from providers and participant representatives. The CCPAC has several work groups, including a quality committee. This process of inclusion of stakeholders has been most effective and is viewed by the OA as a critical element in its quality management strategies (QMS).

The processes Illinois follows to continuously evaluatethe effectiveness of the QMS are the same processes to evaluate the information derived from discovery and remediation activities. The Waiver Quality Management Committee (QMC) System Improvement Log is a dynamic product that is discussed quarterly by key staff of the MA and the OA or MCO regarding progress, updates and evaluation of effectiveness. Effectiveness is measured by impact on performance based on ongoing data collection over time, feedback from participant/guardian interviews, satisfaction surveys, and service providers. Multiple years of data collection will allow the State to evaluate the effectiveness of system improvements over time.

System design changes may be specific to the OA, the MCOs, or both. The purpose of meeting with all parties annually is to provide an arena to see the system holistically, determine how well the system design changes are working and what areas require further improvement. Decisions that are made as a result of these meetings are tracked on the QMC Systems Improvement Log.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

During the quarterly meetings with the OA, IDoA and HFS reviews waiver reports, and the Quality Improvement Strategies. The OA and the MA, as partners discuss updates that both Departments need to address in the future. IDOA also seeks input from its advisory groups on improvements and/or changes to the Quality Improvement Strategy. IDOA continually address issues as they arise, respond and implements strategies to effect changes to performance indicators. The whole QMS is viewed as a continuous ongoing process.

One QMC meeting a year is dedicated as a combined meeting with the MA, the OA, and the MCOs. At this meeting, the entities meet and discuss statewide issues impacting the waiver. During this annual meeting, the OA and the MCOs has on the agenda an overview of the previous year's activities and a discussion of whether changes are needed to the Quality Management Strategy. The MA and the OA see five primary focus areas: These areas are described below.
1) Structure of the QMC: The group reviews the structure of the QMC to determine if it is effective.
2) Trend Analysis: The group evaluates the processes for identifying trends and patterns to assure that issues are being identified.
3) Systems Improvement Log: The group reviews the QMC Systems Improvement Log to assure that all recommendations have been implemented in accordance with agreed upon time lines, and if not, whether there is justification.
4) System Improvement Priorities: The methods for determining system improvement priorities are evaluated to determine effectiveness.
5) Performance Measures: The entities determine whether to make changes in existing performance measures, add measures, or discontinue measures. Other elements of performance measures are reviewed for effectiveness, including: the frequency of data collection, source of data, sampling methodology, and remediation.

The state continuously strives to increase the compliance rate of each performance measure. While the target compliance rate for each performance measure is 100%, the state realizes that it may take multiple system changes over several years to reach the goal of 100% compliance, as well as, all entities involve experience staff changes that require ongoing training.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the*

financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) Requirements concerning the independent audit of provider agencies;

Independent audits of in-home service provider agencies are required by rule 240.1525(b)(1)-(2). The audits must be conducted annually by an independent Certified Public Accountant and submitted to IDoA for review. Staff in the Bureau of Business Services review the audits and ensure each agency required to complete an audit have done so. Any deficiencies or lack of submitted audit(s) are reported to the Office of Community Care Services who initiate corrective and/or contract action on the provider agency until such time as the deficiency is corrected.

All Community Care Program providers are required to submit an annual audit pursuant to 20 ILCS 4.02m.

(b) The financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits;

IDoA and HFS work cooperatively to review rates and provider claims. HFS implements procedures that provide assurance that claims will be coded and paid in accordance with the reimbursement methodology specified in the waiver.

IDoA also has mechanisms in place to ensure that provider agency and CCU billings are coded and reimbursed accurately. The process begins after the Level of Care (LOC) determination is completed. The CCU enters information collected from the assessment into CMIS, a relational computerized database. Numerous edits are performed in CMIS that will not allow a CCU to approve a participant to receive CCP services without eligibility criteria being complete and accurate. CMIS will not allow the CCU to process information when the participant's date of birth indicates the participant is under 60 years of age, and thus not eligible for services through the waiver. A participant cannot be authorized to receive services if the participant has not scored the minimum Level of Care on the DON. Additionally, the CCU cannot authorize more CCP services than that allowed by the service maximum related to the DON score. The data collected in CMIS creates a Case Authorization Transaction (CAT) that is transmitted to IDoA by the CCU.

Once the CAT is sent to IDoA, further edits of the data are performed. CATs can be rejected by IDoA's computer system for a multitude of reasons. The contract numbers for both the CCU and any provider agency authorized are checked against IDoA's file of contract information. If any of the contract numbers are incorrect or not valid for the time period, the CAT will be rejected. IDoA Information Technology and Business Services staff review and update the contract number tables frequently to assure the information is correct.

Edits are also performed based on the type of CAT assessment the CCU has generated. For example, certain information is required for data when the individual will be a CCP participant that is different than a CAT generated when an applicant was denied CCP services. This ensures that all information required to pay a CCP provider is accurate and complete.

Other edits that ensure appropriate billing is submitted by the provider agency include that the CCU cannot authorize CCP services prior to the application date, prior to the date the CCU determined the participant eligible for CCP, or prior to the initial service date of which the provider agency informs the CCU.

Once the CAT has been accepted in IDoAs system for a CCP participant, only the provider agency on the CAT will be authorized to bill beginning after the initial service date. Extensive edits are also conducted at the time of the provider agencys billing. An agency cannot bill for any services that were not authorized by the CCU on the CAT. For example, an ADS cannot bill for transportation if it was not authorized on the CAT; nor can the ADS bill for transportation in a month in which ADS services were not provided.

Provider agencies submit billing to IDoA by either uploading a file from their local computer or entering the data directly on the eCCPIS Internet web pages. If uploading a file from the computer, billing claims will reject for a number of reasons including: if the participant information is not in IDoA's system, the provider contract number is not accurate or current or for an invalid provider service code.

Another safeguard for all provider billings is that the payment will be rejected if the billing was previously submitted. Once a CCU bills for a particular assessment, that assessment will no longer appear as viable to be billed. Provider agencies cannot bill over the authorized number of units for a month of service. Additionally, if one provider agency has already billed for a given month and the participant has switched providers during that month, and the second provider agency attempts to bill for service that exceeds their portion of the month, the eCCPIS will verify that the second provider agency is authorized, and will also reject the billing if that agency bills more than is allowable based on the DON score and the billing by the first agency.

The Medicaid Agency has implemented oversight procedures that provide increased assurance that claims are coded and paid in accordance with the reimbursement methodology specified in the waiver. These processes enable staff to monitor the financial aspects of the waiver for Persons who are Elderly from a global perspective, rather than review a sample of paid claims. The Medicaid Agency determined that reviewing a sample of paid claims was of limited effectiveness and would not likely disclose problematic billings, patterns and/or trends.

The Medicaid Agency staff utilizes its Data Warehouse query capability to analyze the entire dataset of paid waiver claims. The Medicaid Agency utilizes an exception report and review format as a component of the agency's financial accountability activity. Agency staff have constructed database queries that encompass waiver eligibility, coding and payment criteria. Based on these criteria, twice a year the Medicaid Agency conducts analysis of all paid claims and only the claims that were not paid in accordance with set parameters are identified and extracted. The identified exceptions are printed out with all relevant service data. Current exception reports identify paid claims for waiver services to participants who were in a nursing home or who are deceased. In addition to the exception reviews of waiver claims, Medicaid Agency staff conduct targeted reviews of individual waiver services, utilization of waiver services by individual recipient and billing trends and patterns of providers. These reviews are usually conducted on an impromptu basis.

The results of all financial reviews are presented to IDoA personnel under cover memos with supporting claim detail. IDoA advises the Medicaid Agency of corrective actions taken, including adjustments, for all service claims identified by the reviews that were not paid in accordance with defined parameters.

In addition to the HFS post-review and the IDoA edits described above, IDoA also has staff review Hours of Service Calendars (HOSCs) for a sample of participants during Quality Improvement reviews of ADS and homemaker provider agencies. HOSCs are checked for accuracy of completion including: signatures of the participant, worker, and supervisor and accurate total number of units. IDoA staff also compare the number of units on the HOSC to the amount of units billed by the provider agency for that month.

IDoA continuously implements enhancements to the eCCPIS in order to assist CCUs and provider agencies with billing processes. The IDoA seeks input from provider agencies, CCU users of eCCPIS and AAAs on functional improvements to the system. Several reports have been added to the eCCPIS as a result.
IDoA contracts with Shawnee Information Systems Development (SISD) to maintain and update CMIS and provide technical assistance to all CCU users. SISD conducts periodic trainings for CCU users on how to enter data and utilize reports available in CMIS.

c) The agencies responsible for conducting the financial audit program:

HFS and IDoA and the are responsible for conducting the financial audit program.

For participants enrolled in an MCO, the Medical agency's internal and external auditing procedures will ensure that payments are made to a managed care entity only for eligible persons who have been properly enrolled in the waiver.

The Plans are responsible for reviewing payments made directly to providers for waiver services as part of the MCO contract. The Plans must have an internal process to validate payments to waiver providers. This includes the claims processing system verifying an individual's waiver eligibility prior to paying claims. This will be reviewed in the Readiness Review.

Post-payment plans of care and financial reviews are also conducted. Additionally, the Plans will implement call-in checks for some waiver services to verify a provider was on-site as required during the specified time(s) and post-service verification forms for participants to validate they received services.

Regarding avoidance of participant coercion, Participant choice is a requirement of the CCP Administrative Rule 240.330. Upon assessment, care coordinators discuss service options. Once a participant choses to receive CCP services, he or she is given a choice of provider agency(ies). Care coordinators are trained to educate participants and provide an informed choice on the available providers. IDoA utilizes a Vendor Section Form, which the participant signs, to document participant choice of providers.

The State has several measures in place to ensure that claims describe services actually rendered. First, errors in billing may be found by the Care Coordination Unit or CCP provider. Second, the MA's claiming system does not allow the OA to submit a claim for a time period in which the participant was not active on Medicaid or was active on another waiver. Further, the OA has implemented systematic checks in the billing and case management systems, to combat errors and

fraud, which verify client identification, date of death and MCO eligibility dates. Each entity has the ability to review the identified errors and send in a corrective billing through the OA system during the current fiscal year or they must remit a check for errors in prior fiscal years.

Other errors found in billing are identified and provided to the respective providers and Care Coordination Units via the OA recoupment reports on the OA eCCPIS portal.

The OA fiscal division also sends letters to the providers and Care Coordination Units regarding the amount owed and the process for review and submission of payment. The OA submits the corrected billing through the regular electronic feed to the Medicaid agency.

Additionally the MA's Office of Inspector General (OIG) has jurisdiction to investigate concerns of waste, fraud, and abuse. The OA and the MA OIG work closely together to refer concerns for each entity to investigate. Finally, to ensure billing submissions match services provided, QI reviews are conducted by the IDoA for each IDoA contracted CCP provider at least once during each three-year contract cycle.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
46I: # and % of payments that were paid for participants who were enrolled in the waiver on the date the service was delivered. N: # of OA and MCO payments made for participants who were enrolled in the waiver on the date the service was delivered. D: Total # of OA and MCO payments.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS Medical DW Encounter Data

Responsible Party for	***Frequency of data***	***Sampling Approach****(check*

data collection/generation *(check each that applies):*	***collection/generation*** *(check each that applies):*	*each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☒ ***Other*** *Specify:* *MCO*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☒ ***Other*** *Specify:* *Semi-Annually*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *MCO*	☐ ***Annually***
	☐ ***Continuously and Ongoing***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☒ ***Other*** *Specify:* *Semi-Annually*

Performance Measure:
47I: # and % of payments there were paid for services that were specified in the participant's service plan. N: # of OA and MCO payments made that are specified in the participant's service plan. D: Total # of OA and MCO payments.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS Medical DW and eCCPIS MCO Reports

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☒ ***Other*** *Specify:* *MCO*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☒ ***Other*** *Specify:* *Non-representative sample*
	☒ ***Other*** *Specify:* *Semi-Annually*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *MCO*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *Semi-Annually*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
48I: # and % of payments that were paid using the correct rate as specified in the waiver application. N: # of OA and MCO payments using the correct rate as specified in the waiver application. D: Total # of OA and MCO payments.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS Medical DW Encounter Data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100%***

		Review
☐ ***Sub-State Entity***	☒ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☒ ***Other*** *Specify:* *MCO*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☒ ***Other*** *Specify:* *semi-annually*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *MCO*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *Semi-Annually*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the*

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

For those functions delegated to the OA and the MCOs, the MA is responsible for oversight and monitoring to assure compliance with federal assurances and performance measures. The MA monitors both compliance levels and timeliness of remediation by the OA and MCOs through fiscal monitoring and ongoing reporting by the OA and MCO.

The MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the OA and the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The MA will pull the sample annually and adjust the methodology as additional MCOs are enrolled to provide long term services and supports.

For the administrative claims review, the MA reviews the entire DoA claim related to Medicaid administrative costs.

For the waiver claims review, the Medicaid Agency staff utilize the Data Warehouse query capability to analyze the entire dataset of paid waiver claims. The Medicaid Agency utilizes an exception report and review format as a component of the agency's financial accountability activity. Agency staff have constructed database queries that encompass waiver eligibility, coding and payment criteria. Based on these criteria, twice a year the Medicaid Agency conducts analysis of all paid claims and only the claims that were not paid in accordance with set parameters are identified and extracted. This review will include capitation payments made to MCOs and encounter claims submitted by MCOs.

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in HFS' contracts with Integrated Care Program MCOs that provide waiver services. Contracts specify numerators, denominators, sampling approaches, data sources, etc.
Through its contract with the EQRO, the MA monitors both compliance of PMs and timeliness of remediation for those waiver participants enrolled in an MCO through consumer surveys and quarterly record reviews. Participants in MCOs are included in the representative sampling.

Additionally, the Plans will implement call-in checks for some waiver services to verify a provider was on-site as required during the specified time(s) and post-service verification forms for participants to validate they received services.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

46I: The MA will require the OA to void the federal claim for services provided prior to the customers' waiver enrollment. Remediation must be completed within 30 days. HFS will adjust the federal claim for services provided by the MCO prior to the customers' waiver enrollment. Remediation must be completed within 30 days.

47I:The OA/MCO will determine whether the service was authorized. If authorized, the OA/MCO will revise customer service plan; If not authorized, the OA/MA will void the federal claims that were not consistent with service plans. Remediation must be completed within 30 days.

48I:The MA will require that the OA either recoup the overpayment or repay at correct rate. Remediation must be completed within 30 days.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *MCO*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *Semi-annually*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The Department of Healthcare and Family Services (HFS), Illinois' State Medicaid Agency, retains and exercises final authority over payment rates. It does so in collaboration with the OA, which develops the proposed rates and shares the proposed rates and methodology with HFS. Rates of payment for program services since the initial 1915(c) waiver was approved have been established and updated as described below.
Every year, the State will rebase the CCP services within 5 years from the previous rebasing.
In addition to this rebasing process, the rates for each waiver service are reviewed annually to ensure budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. In reviewing fixed unit rates of reimbursement, the State takes into consideration (1) service utilization and cost information, and (2) current market conditions and trend analyses. The State would recommend to move to adjust rates if it found significant changes in existing or applying provider numbers or in wait lists for specific waiver services. Further review would also be triggered by indication of lack of client choice of providers for services, or by unusual utilization trends.

Emergency Home Response Service:
EHRS is administered by the Illinois Department on Aging (IDOA) Community Care Program (CCP) services as part of the Medicaid Home and Community-Based Services (HCBS) Waiver program authorized in §1915(c) of the Social Security Act. It is a 24-hour emergency communication link to assistance outside the home for older adults with documented health and safety needs and mobility limitations. This service is provided by a two-way voice communication system consisting of a base unit and an activation device worn by the participant that will automatically link the older adult to a professionally staffed support center.
The State worked with an external vendor to review its rates to determine if the current rates are efficient, cost effective and allow for the purchase of services at the lowest rate that will ensure access to waiver services by multiple providers. Based upon its analysis, the State proposes to increase the Medicaid reimbursement rate for EHRS installation. Based upon a rate comparison with other states, it was determined that Illinois' current installation rate of $30.00 is below the Medicaid reimbursement levels established in other states. Additionally, is also below the installation cost incurred by existing EHRS providers who charge an installation fee. (Some providers blend the installation cost into their monthly monitoring charge.) In developing the proposed rate increase, the State examined Medicaid reimbursement rates paid in other states, as well as analyzed installation costs incurred by existing contracted and non-contracted providers. The State examined the cost components underlying into the installation activity, which could include administrative costs (completing paperwork, contacting the client, scheduling an appointment), training and testing (include training the client to properly use the device and testing the range capacity within the device) and the cost of transportation to the client's home to perform the installation. Based on this analysis, the State will employ a methodology of frequent, ongoing review to ensure that the installation rate remains in line with similarly situated programs in other states and is reflective of the cost of providing the installation service. The State is proposing an increase of $10 to the current installation rate.
Below is the proposed EHRS Installation rate:
EHRS Installation: $40

Adult Day Service/Adult Day Service Transportation:
Adult Day Service (ADS) is defined as the direct care and supervision of adults aged 60 or over in a community-based setting for the purpose of providing personal attention and promoting social, physical, and emotional well-being in a structured setting.

The State worked with an external vendor to review its rates to determine if the current rates are efficient, cost effective and allow for the purchase of services at the lowest rate that will ensure access to waiver services by multiple providers. Currently, the ADS rate is based on a fee-for-service structure. Providers are paid on an hourly basis for ADS services. The ADST rate is a separate fixed fee rate calculated independently of the ADS rate. Providers are paid per one-way trip for ADST. These rates were originally established by legislation and have been subject to proposed legislative increases over the past few years. A study of day service rates was last conducted in 2000, and rates were last increased in 2008.

The State used multiple means to obtain necessary data to complete a thorough rate analysis for the ADS and ADST programs. This process included conducting focus groups which included participants, reviewing existing state data, and developing and distributing two provider surveys.

Ultimately, the rate increase recommended by the state will better accommodate program standards (particularly, staffing ratios) and all the other significant rate inputs.
Below are the proposed ADS and ADST rates:

Adult Day Service $ 14.30
Adult Day Service Transportation $ 10.29

The State believes this proposed rate will best support participants and their providers.

In-Home Service:
In-Home services are general non-medical support by supervised homecare aides who receive specialized training in the provision of in-home services. The services provided through this program include:
- *Teaching/performing of meal planning and preparation*
- *Routine housekeeping*
- *Shopping skills/tasks*
- *Home maintenance and minor repairs*
- *Assisting with self-administrated medication*
- *Assisting with shopping, errands, personal care tasks*
- *Escorting participant to medical facilities or individual business*

These services are provided to participants based on their person-centered plan of care with the goal of maintaining, strengthening, and safeguarding the functioning of the participants in their own home.
Currently, the In-Home service providers are paid a fixed unit rate of $18.29 per hour of service. This rate is designed to include both administrative and direct service costs. The rates are not geographically based and do not include room and board. The In-Home rates were originally established by requesting information from applicants on their costs for providing the service and the size of the population each applicant projected it could serve. The rate was then established at one standard deviation above the mean of the weighted costs received. Subsequent rates added cost of living adjustments (COLA) to the previous rate or through rates agreed upon between the State and Service Employees International Union (SEIU), union agreements, and most recently a legislative increase.
The State worked with an external vendor to review its rates to determine if the current rates are efficient, cost effective and allow for the purchase of services at the lowest rate that will ensure access to waiver services by multiple providers.

The State used multiple means to obtain necessary data, including In-Home service claims data for analysis, cost and service related information to research for other comparable programs, and conducted eight in-person focus groups in different regions of Illinois.

Below is the proposed In-Home Service rate:

In-Home Service $ 20.28
The State believes this proposed rate will best support participants and their providers.
Automated Medication Dispenser (AMD):
AMD payments consist of a one-time installation fee and a separate monthly rate for ongoing rental and technical support of the AMD. The installation rate covers maintaining adequate local staffing levels of qualified personnel to service necessary administrative activities, installation, and in-home training. The monthly rental rate covers maintaining administrative and technical support to program machines, providing 24 hour technical assistance, signal monitoring, troubleshooting, providing machine maintenance and repair requests in a timely manner, sending notifications on missed doses, and providing reports as requested by IDoA.
The AMD fixed unit rates were established in 2013, pursuant to an RFI process that allowed for the calculation and subsequent establishment of a fixed rate and research on other states' approaches to obtaining Medicaid reimbursement for the provision of AMD services. IDoA sent RFI questions to all of the providers that were contracted with IDoA for EHRS. Four vendors with 7 different units responded to IDoA's request for information with information on rates and unit specifications. The average quotes for installation and monthly monitoring from all providers were $45.00 and 38.16, and the median quotes were $50.00 and $36.00. However, for the two providers who met IDoA's service specifications, the quoted rates for installation and monitoring were $50 and $40, and $60 and $60. Based on this information, IDoA chose, and HFS approved, rates of $50 for installation and $40 for monitoring. Those figures were at or near the average and were the lowest of the rates provided by the vendors that met minimum requirements.
Although IDoA's research into other states' rates for the same service revealed several states with service or payment methodologies too distinct to allow comparison, IDoA concluded that these rates were comparable to those quoted to Wisconsin. In response to that state's RFI, three vendors quoted monthly AMD rates of %57, $44.95, and $26.95.

Rates are not geographically based and do not include room and board.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Fee for Service Providers are paid by the OA. Bills submitted by the provider, for participants, are generated through the OA eCCPIS billing system. IDOA will not accept a bill for payment unless that service has been authorized systematically in the case management system and verified by the eCCPIS rules engine. The case management system provides authorized services and service cost maximums for the participant as per the determination of need/assessment. The rules engine validates whether the participant is on the Public Health death record or in managed care, whether the name and social security number is valid, and whether previous billing for this service has been submitted. This billing submission process is the same for all Medicaid and non-Medicaid participants.

Valid billing submissions for each participant are then submitted for Medicaid eligibility to HFS (MA) on a weekly basis. HFS then returns a weekly file to IDOA with an OBRA indicator code for all those participants who met the eligibility criteria. Participants who appear to be eligible but were not returned with an OBRA indicator code are researched by the OA staff and re-submitted. If validation issues are corrected, HFS will provide the OA OBRA indicator code.

The OBRA indicator code is applied to IDOA participants if; the participant is enrolled in Medicaid for the dates that the billing occurred, the participant is not receiving other Medicaid services, the participant is not enrolled in a MCO.

All billing that was accepted by HFS from OA and the OBRA indicator code was applied is eligible for federal financial participation. Federal financial claiming is submitted by MA.

To ensure billing submissions match services provided, QI reviews are conducted by the OA for each OA contracted CCP provider at least once during a contract cycle (3 years). The review is performed by OA staff as an independent review. This ongoing administrative activity allows the OA to ensure that providers and CCUs are adhering to the rules, regulations, policies, and procedures of the CCP.

CCP service claims are reviewed by the OA. The OA chooses a random stratified sample from IDOA eCCPIS billing records. The sample includes both participants in the waiver program and participants covered by General Revenue funding. If the OA is aware of a particular participant's concern via the complaint/SIP process or other means, that participant's file is included in the sample. A minimum of 5 participant files are chosen for each contract number reviewed.

Documentation reviewed includes, but is not limited to, date of initiation of service, complaint follow-up, reporting concerns to the CCU, etc. Verification is also thoroughly reviewed that billing submitted to the OA by the provider matches what the participant acknowledged for provision of service, including dates, and in/out times by the homecare aide. In-Home Service providers are required to utilize Electronic Visit Verification (EVV) to electronically track and document time spent by the homecare aide in the participant's residence.

Any billing errors found during the QI review require the provider agency to submit negative billings to correct the error.

Monthly capitated rates are paid by the Medicaid Agency to the Managed Care Organizations (Plans). This payment is generated by the MMIS based on participants'' eligibility for waiver services as identified in the database system. The Plans only receive payment for individuals eligible for waiver services. The MCO payment process is automated to generate a monthly capitation to the health plans based on the rate cell of each enrollee each month. The MA reviews to ensure the accurate rate is entered into the system, and also spot checks payment reports to ensure payments are made correctly. In addition, the MCOs are required to review their monthly payment and report to the Department any discrepancies.

In general, the rate cells for the Medicaid Component are stratified by age (21-64 and 65+), geographic service area (Greater Chicago and Central Illinois), and setting-of-care. Capitation Rate updates will take place on January 1st of each calendar year. MCOs will be provided a rate report, to be signed by MA and MCO, on an annual basis for the upcoming calendar year.

The State has a monthly capitation program that reads the State's Recipient Database to determine who is enrolled with a particular MCO. The program includes logic that uses the enrollee's eligibility criteria to determine the appropriate rate cell to be used in generating the payment. As a result of this process, a file is created of MCO schedules which are then sent on to the Comptroller for payment. Once the payment has been made by the Comptroller, a file is sent back to HFS by the Comptroller that includes a warrant number and date. HFS then creates a HIPAA 820 files for each MCO. The 820 file contains the detailed payment information on each of the MCO's enrollees. The Plans are required to have internal processes to validate payments to waiver providers. The Plans' claims processing system must verify an individual's waiver eligibility prior to paying claims.

Post -payment plans of care and financial reviews are also conducted, to ensure that plans of care are consistent with needs identified in individuals' assessments. Additionally, the Plans will implement call-in checks for some waiver services to verify a provider was on-site as required during the specified time(s) and post-service verification forms for participants to validate they received services.

The MCO payment process is automated to generate a monthly capitation to the health plans based on the rate cell of each enrollee each month. The State reviews to ensure the accurate rate is entered into the system, and also spot checks payment reports to ensure payments are made correctly. In addition the MCOs are required to review their monthly

payment and report to the MA for discrepancies.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Provider billings are validated by IDoA to verify the effective date of the participant's authorization for services as included in an approved plan of care. Paid Claims are passed through to HFS and MMIS processing edits are initiated for Medicaid and waiver eligibility. Lastly, HFS performs post-payment plan of care and financial reviews.

Oversight to ensure that appropriate services were provided occurs in a variety of methods. Working with the participant/authorized representative, the Care Coordinator authorizes the appropriate type and amount of CCP services via a signed Client Agreement. This information is included in the electronic Community Care Program Information System (eCCPIS) through which CCUs and CCP providers submit billings to the OA. The eCCPIS contains several features designed to ensure appropriate billing and services, including: 1) eCCPIS security measures do not allow for unauthorized individuals to submit billings; 2) CCUs and CCP providers cannot submit billings that are not authorized; 3) CCP providers cannot submit billings over the authorized amount; and 4) participants/authorized representatives validate services provided by CCP providers via signed electronic or paper means.

Monthly capitated rates are paid by the Medicaid Agency to the Managed Care Organizations (Plans). This payment is generated by the MMIS based on participants'eligibility for waiver services as identified in the database system. The Plans only receive payment for individuals eligible for waiver services. The MCO payment process is automated to generate a monthly capitation to the health plans based on the rate cell of each enrollee each month. The MA reviews to ensure the accurate rate is entered into the system, and also spot checks payment reports to ensure payments are made correctly. In addition, the MCOs are required to review their monthly payment and report to the Department any discrepancies.

In general, the rate cells for the Medicaid Component are stratified by age (21-64 and 65+), geographic service area (Greater Chicago and Central Illinois), and setting-of-care.
Capitation Rate updates will take place on January 1st of each calendar year. MCOs will be provided a rate report, to be signed by MA and MCO, on an annual basis for the upcoming calendar year.

The State has a monthly capitation program that reads the State's Recipient Database to determine who is enrolled with a particular MCO. The program includes logic that uses the enrollee's eligibility criteria to determine the appropriate rate cell to be used in generating the payment. As a result of this process, a file is created of MCO schedules which are then sent on to the Comptroller for payment. Once the payment has been made by the Comptroller, a file is sent back to HFS by the Comptroller that includes a warrant number and date. HFS then creates a HIPAA 820 files for each MCO. The 820 file contains the detailed payment information on each of the MCO's enrollees.

The Plans are required to have internal processes to validate payments to waiver providers. The Plans claims processing system must verify an individual's waiver eligibility prior to paying claims.

Post-payment plans of care and financial reviews are also conducted, to ensure that plans of care are consistent with needs identified in individuals' assessments. Additionally, the Plans will implement call-in checks for some waiver services to verify a provider was on-site as required during the specified time(s) and post-service verification forms for participants to validate they received services.

The MCO payment process is automated to generate a monthly capitation to the health plans based on the rate cell of each enrollee each month. The State reviews to ensure the accurate rate is entered into the system, and also spot checks payment reports to ensure payments are made correctly. In addition the MCOs are required to review their monthly payment and report to the MA for discrepancies.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

IDoA makes payments from a central computer system and submits to the comptroller's office for payment. Claims are then sent to HFS for further editing and for Medicaid claiming. The audit trail is established through state agency approved rates, service plan authorizations, documentation of service delivery, and computerized payment and claiming systems cross-matched with the MMIS.

Monthly capitated rates are paid by the Medicaid Agency to the Managed Care Organizations (Plans). This payment is generated by the MMIS based on participantseligibility for waiver services as identified in the database system. The Plans only receive payment for individuals eligible for waiver services.

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The limited fiscal agent is a function of the operating agency IDoA.

The provider signs the three-party Medicaid provider agreement that allows voluntary reassignment of pay. The operating agency makes payments directly to providers of waiver services and certifies those expenditures to the Medicaid agency.

The operating agency explains to providers that the waiver agreement voluntarily reassigns payment responsibility to the operating agency and that they have the option to bill HFS, directly, if they choose.

The Operating Agency passes the detail expenditure data once a month via an electronic tape to HFS, the Single Statewide Medicaid claiming agency for the State of Illinois. The data is fed into the Medical Management Information System (MMIS) and is subject to edits to ensure the information provided is accurate and that the services/providers are eligible for federal match under Title XIX. Should any claims have inaccurate information those claims are rejected by the system and a file of the rejected claims is passed back to the Operating agency for their review. Claims that pass through the system without error pass into the Management Administrative Reporting System (MARS) reporting unit. The MARS unit is responsible for generating the reports to the Bureau of Federal Finance (BFF) who use the reports to claim Medicaid expenditure data quarterly on the CMS 64. MARS also has a series of edits and codes that are used to filter data to ensure accuracy and to determine to what program the expenditure should be reported. The BFF reports the expenditures on the CMS 64 on a quarterly basis 30 days after the quarter's end.

In accordance with the Cash Management Improvement Act (CMIA), the BFF draws down federal monies from the Title XIX grant for the waiver on a weekly basis and deposits the funds into the General Revenue Fund (GRF). The amount to be drawn is an estimate derived by using historical expenditure data. Once the CMS 64 is completed at the quarters end, the BFF reconciles the estimated cash draw to the actual expenditures reported on the CMS 64. The reconciling expenditure amount is either added to or subtracted from the grant award depending on whether or not the adjustment is over or under the original estimated amount.

☒ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Not applicable.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

○ ***No. The state does not make supplemental or enhanced payments for waiver services.***

◉ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

The only service that will have an enhanced rate is Homemaker Services. This service would be only for in-home service provider agencies that provide health insurance. The source of the non-federal share of the enhanced payments would be the State of Illinois. Each service provider that received the enhanced rate would be able to retain 100% of the total computable expenditure claimed by the Medicaid Agency to CMS. With the public notice and the continuous posting of the rate increase on the HFS website, it is believed that the public is fully aware and that the intent is clear as to which providers are eligible for the enhanced payment.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- (●) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ( ) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ( ) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ○ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ◉ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

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ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the***

delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

◉ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***not selected***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☐ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☒ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The operating agency receives the non-federal share through the General Revenue Fund appropriations.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ◉ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	8054.94	3294.68	11349.62	28744.16	2208.99	30953.15	19603.53
2	8271.10	3522.74	11793.84	29981.97	2216.08	32198.05	20404.21
3	5077.75	3766.59	8844.34	31273.08	2223.19	33496.27	24651.93
4	6121.04	4027.32	10148.36	32619.79	2230.32	34850.11	24701.75
5	6120.97	4306.10	10427.07	34024.50	2237.47	36261.97	25834.90

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	85090	85090
Year 2	92054	92054
Year 3	105618	105618
Year 4	122447	122447
Year 5	143101	143101

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay is based on the last five 372 Reports for WY 1-3.

The average length of stay for WYs 4-5 is based on the actual length of stay in waiver years 1 through 3 (November 1, 2016 through October 31, 2019).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Estimates are based on an analysis of data for FY2010 through FY2014 (estimated) historical average percent of change, comprised of rate increases and case mix changes of current utilization and costs among participants enrolled in the waiver. These estimates were subsequently projected forward using the same historical percentage of growth for the total unduplicated client count for fee-for-service and applied the same percent of growth to each individual waiver service.
The In-Home Service rate was raised from $18.27 to $19.43 to reflect the action of the Illinois General Assembly, Public Act 100-0023.

For waiver participants receiving waiver services through a Managed Care Organization (MCO), a capitated rate specific to waiver services is used. The capitation rate is certified as actuarially sound. The capitation rate is developed based on the historical fee-for-service payments from SFY 2013-2015. The historical waiver experience will be trended forward to the contract rating years. Further, adjustments will be applied for policy and program changes, as well as anticipated managed care impact adjustments. The capitation rate will also include an administrative and risk load appropriate for the MCO.

Since not all waiver recipients are enrolled in an MCO, Factor D will be developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.

For all services the initial estimates for growth were too high. Based on the new data, the estimates of a decrease of 14% in WY 4 and 30% in WY 5 are more accurate.

For Adult Day Services, Homemaker Services, Automated Medication Dispenser Services and Emergency Home Response Services, an analysis was done with FFS data regarding participants. FFS Participants were decreased and managed care participants were increased in response to HealthChoice Illinois (HCI) which will expand managed care to all counties in Illinois. State Fiscal Year 2015 data was reviewed to derive and average mix of users among FFS and managed care programs that could be applied to HCI enrollment. Average units per used for managed care participants were estimated such that the average length of stay on the waiver for FFS and managed care participants combined was consistent with the average length of stay on the waiver for SFY 2013-2016. Relative utilization between managed care populations was estimated based on SFY 2016 experience. The average cost per unit for the managed care populations were calibrated to be consistent with recent capitation rate development for these managed care populations, including adjustment for trend.

The waiver year 3 participants was estimated based on participant counts as of July 1, 2019. The participant count was annualized to represent the entire waiver year 3 participant count based on historic seasonality and completion factors in the Elderly Waiver enrollment patterns. Unduplicated participant projections for waiver years 4 and 5 are trended from waiver year 3 participants based on the enrollment growth trends illustrated in the approved filing.
The number of users by service were estimated using the estimated unduplicated participants and the estimated FFS user penetration rate for each service in waiver years 1 and 2. For AMD-related services, a new service effective July 2018, the assumed user penetration rate for waiver year 3 is consistent with the previously filed Appendix J-2-d. associated installation services were assumed to decrease for waiver years 4 and 5. The user projections by population in waiver years 4 and 5 reflect the July 1, 2019 distribution by population, which is the effective date for statewide mandatory managed care enrollment.
For the services reimbursed at an hourly rate, the average units per user are based upon the estimated units per day and the estimated average length of stay on the waiver for each population. The estimated units per day are based upon estimated waiver years 1 and 2 FFS experience.
For the services reimbursed on a monthly basis, the average units per user are based upon the estimated units per months and the estimated length of stay on the waiver for each waiver population. The estimated units per month are based upon waiver years 1 and 2 FFS experience.
Average cost per unit projections were changed to reflect the State's fee schedule effective September 1, 2019 for the following services: ADS from $9.02 per hour to $14.02 per hour; ADST from $8.30 per hour to $10.29 per hour; EHRS from $30 per installation to $40 per installation, and; In-home services from $18.29 per hour to $20.28 per hour.
The average cost per unit for waiver year 3 represents a blend of the historical fee schedule amounts for 10 months and the newly effective rates for 2 months. With the exception on in-home services, waiver years 4 and 5 average cost per unit projections reflect a complete year at the newly effective rates.
Average cost per unity projections were changed to reflect an additional fee schedule change effective January 1,

2020 for in-home services to $21.84 per hour. The average cost per unit for waiver year 5 represents a blend of the September 1, 2019 fee schedule amount for 2 months and the January 1, 2020 fee schedule amount for 10 months. Waiver year 5 average cost per unit projections reflect a complete year at the January 1, 2020 fee schedule amount.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Fee-for-service Population:

We have assumed the cost per unit will remain the same. We have calculated the units per user by adjusting the aggregate number of units in both the fee-for-service and MCO populations. The Factor D' percentage is a 6.92% increase.

MCO Population:

We have distributed an average monthly capitation rate of $1,700 across the rate categories. We have assumed that the average length of stay on the waiver would be the same for both the fee-for-service and MCO populations. We have assumed that the average units per user would be consistent with the current Factor D. We have assumed the same ratio of users per service based on the current Factor D. The cost per unit of service was used as the residual calculation after determining the other variables.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G is the institutional cost per person for those over 60 years. Factor G is estimated to increase by 4.30% each year for WY'10 - WY'14 due to utilization. The 4.30% increase incorporates both case mix increases and rate increases to Nursing Homes for each waiver year.

For participants receiving nursing facility services through a Managed Care Organization (MCO), a capitation rate specific to nursing facility services is used. The capitation rate was developed based on historical fee-for-service nursing facility costs from state fiscal years (SFY) 2008 through 2011. The historical nursing facility experience was trended forward to the contract rating years.

Since not all nursing facility residents are enrolled in an MCO, Factor G was developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.

Since not all nursing facility residents are enrolled in an MCO, Factor G will be developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G Prime is estimated to increase by .32% for the next five waiver years. This percentage is based upon the average historical percent change for WY'10 - WY'14 (estimated). Actual ancillary expenditures per capita for Institutional residents and carried forward to WY'14- WY'20. These estimates include case mix and rate increases. Factor G Prime is based on ancillary services received by the comparable population of nursing home residents over age 60.

The projections were based on utilization of Medicaid ancillary services for waiver participants and nursing facility participants. Waiver participants receive additional services that are covered by non-Medicaid funded entities. Examples include Title III services, home-delivered meals, and medication monitoring services provided through various demonstration projects. The combination of waiver services and other services, as described above may assist in lowering the need for the Medicaid ancillary services.

The capitation rate nursing facility residents enrolled in Managed Care Organization includes both nursing facility services, as identified in Factor G, and ancillary medical and pharmacy services. The capitation rate is certified as actuarially sound. The capitation rate developed based on historical fee-for-service costs for ancillary services for nursing facility residents from state fiscal years 2010 through 2014. The historical ancillary service expenditures were trended forward to the contract rating years. The capitation rate also includes an administrative and risk load appropriate for the MCO.

Since not all nursing home residents are enrolled in an MCO, Factor G was developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Service	
In-Home Service	
Automated Medication Dispenser (AMD)	
Emergency Home Response Service	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**26672197.35**
Adult Day Service	☐	Hour	4179	462.54	9.02	**17435251.03**	
Adult Day Service Capitated	☒	Hour	280	307.00	16.77	**1441549.20**	
Adult Day Service MMAI	☒	Hour	279	515.00	10.63	**1527371.55**	
Adult Day Service MLTSS	☒	Hour	140	308.00	9.02	**388942.40**	
Adult Day Service Transportation	☐	Hour	3864	154.00	8.30	**4938964.80**	
Adult Day Service Transportation Capitated	☒	Hour	259	105.00	15.43	**419618.85**	
Adult Day Service Transportation MMAI	☒	Hour	258	163.00	9.78	**411288.12**	
Adult Day Service Transportation MLTSS	☒	Hour	129	102.00	8.30	**109211.40**	
In-Home Service Total:							**652874405.47**
Homemaker	☐	Hour	69065	427.00	18.27	**538796093.85**	
Homemaker Capitated	☒	Hour	4634	378.00	33.97	**59503618.44**	
Homemaker MMAI	☒	Hour	4628	427.00	21.53	**42546638.68**	
Homemaker MLTSS	☒	Hour	2310	285.00	18.27	**12028054.50**	
Automated Medication Dispenser (AMD) Total:							**820.00**
Automated Medication Dispenser Service	☐	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Service Capitated	☒	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser	☒	Month	1	1.00	40.00	**40.00**	

GRAND TOTAL:	**685394896.65**
Total: Services included in capitation:	119144379.97
Total: Services not included in capitation:	566250516.68
Total Estimated Unduplicated Participants:	**85090**
Factor D (Divide total by number of participants):	**8054.94**
Services included in capitation:	1400.22
Services not included in capitation:	6654.72
Average Length of Stay on the Waiver:	266

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service MMAI							
Automated Medication Dispenser Service MLTSS	☒	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Installation	☐	One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation Capitated	☒	One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation MMAI	☒	One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation MLTSS	☒	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Service	☐	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service Capitated	☒	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service MMAI	☒	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service MLTSS	☒	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Installation	☐	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation Capitated	☒	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation MMAI	☒	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation MLTSS	☒	One-Time	1	1.00	50.00	**50.00**	
Emergency Home Response Service Total:							**5847473.83**
Emergency Home Response Service	☐	Month	22203	8.00	28.00	**4973472.00**	
Emergency Home	☒					**249471.52**	

GRAND TOTAL:	**685394896.65**
Total: Services included in capitation:	119144379.97
Total: Services not included in capitation:	566250516.68
Total Estimated Unduplicated Participants:	**85090**
Factor D (Divide total by number of participants):	**8054.94**
Services included in capitation:	1400.22
Services not included in capitation:	6654.72
Average Length of Stay on the Waiver:	266

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response Service Capitated		Month	599	8.00	52.06		
Emergency Home Response Service MMAI	☒	Month	1484	8.00	32.99	391657.28	
Emergency Home Response Service MLTSS	☒	Month	743	5.00	28.00	104020.00	
Emergency Home Response Service Install	☐	One-time	3551	1.00	30.00	106530.00	
Emergency Home Response Service Install Capitated	☒	One-time	186	1.00	55.78	10375.08	
Emergency Home Response Service Install MMAI	☒	One-time	237	1.00	35.35	8377.95	
Emergency Home Response Service Install MLTSS	☒	One-time	119	1.00	30.00	3570.00	

GRAND TOTAL:	**685394896.65**
Total: Services included in capitation:	119144379.97
Total: Services not included in capitation:	566250516.68
Total Estimated Unduplicated Participants:	**85090**
Factor D (Divide total by number of participants):	**8054.94**
Services included in capitation:	1400.22
Services not included in capitation:	6654.72
Average Length of Stay on the Waiver:	266

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**29792813.81**
Adult Day Service	☐	Hour	4324	462.54	9.02	**18040207.10**	
Adult Day Service Capitated	☒	Hour	325	307.00	17.11	**1707150.25**	
Adult Day Service MMAI	☒	Hour	628	515.00	10.84	**3505872.80**	
Adult Day Service MLTSS	☒	Hour	1	1.00	8.30	**8.30**	
Adult Day Service Transportation	☐	Hour	3998	153.65	8.30	**5098629.41**	
Adult Day Service Transportation Capitated	☒	Hour	300	105.00	15.74	**495810.00**	
Adult Day Service Transportation MMAI	☒	Hour	581	163.00	9.98	**945135.94**	
Adult Day Service Transportation MLTSS	☒	Hour	1	1.00	0.01	**0.01**	
In-Home Service Total:							**725310058.35**
Homemaker	☐	Hour	71461	426.81	18.27	**557239922.12**	
Homemaker Capitated	☒	Hour	5375	378.00	34.65	**70400137.50**	
Homemaker MMAI	☒	Hour	10416	427.00	21.96	**97669998.72**	
Homemaker MLTSS	☒	Hour	1	1.00	0.01	**0.01**	
Automated Medication Dispenser (AMD) Total:							**550.04**
Automated Medication Dispenser Service	☐	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Service Capitated	☒	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser	☒	Month	1	1.00	40.00	**40.00**	

GRAND TOTAL:	**761387775.35**
Total: Services included in capitation:	175950448.24
Total: Services not included in capitation:	585437327.11
Total Estimated Unduplicated Participants:	**92054**
Factor D (Divide total by number of participants):	**8271.10**
Services included in capitation:	1911.38
Services not included in capitation:	6359.72
Average Length of Stay on the Waiver:	266

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service MMAI							
Automated Medication Dispenser Service MLTSS	☒	Month	1	1.00	0.01	**0.01**	
Automated Medication Dispenser Installation	☐	One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation Capitated	☒	One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation MMAI	☒	One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation MLTSS	☒	One-Time	1	1.00	0.01	**0.01**	
AMD & EHRS Service	☐	Month	1	0.00	65.00	**0.00**	
AMD & EHRS Service Capitated	☒	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service MMAI	☒	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service MLTSS	☒	Month	1	1.00	0.01	**0.01**	
AMD & EHRS Installation	☐	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation Capitated	☒	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation MMAI	☒	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation MLTSS	☒	One-Time	1	1.00	0.01	**0.01**	
Emergency Home Response Service Total:							**6284353.15**
Emergency Home Response Service	☐	Month	22973	7.72	28.00	**4965843.68**	
Emergency Home	☒					**295291.60**	

GRAND TOTAL:	**761387775.35**
Total: Services included in capitation:	175950448.24
Total: Services not included in capitation:	585437327.11
Total Estimated Unduplicated Participants:	**92054**
Factor D (Divide total by number of participants):	**8271.10**
Services included in capitation:	1911.38
Services not included in capitation:	6359.72
Average Length of Stay on the Waiver:	266

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response Service Capitated		Month	695	8.00	53.11		
Emergency Home Response Service MMAI	☒	Month	3340	8.00	33.65	899128.00	
Emergency Home Response Service MLTSS	☒	Month	1	1.00	0.01	0.01	
Emergency Home Response Service Install	☐	One-time	3674	0.84	30.00	92584.80	
Emergency Home Response Service Install Capitated	☒	One-time	216	1.00	56.90	12290.40	
Emergency Home Response Service Install MMAI	☒	One-time	533	1.00	36.05	19214.65	
Emergency Home Response Service Install MLTSS	☒	One-time	1	1.00	0.01	0.01	

GRAND TOTAL:	**761387775.35**
Total: Services included in capitation:	175950448.24
Total: Services not included in capitation:	585437327.11
Total Estimated Unduplicated Participants:	**92054**
Factor D (Divide total by number of participants):	**8271.10**
Services included in capitation:	1911.38
Services not included in capitation:	6359.72
Average Length of Stay on the Waiver:	266

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**16301380.76**
Adult Day Service	☐	Hour	2068	399.18	9.02	**7446048.24**	
Adult Day Service Capitated	☒	Hour	528	376.60	17.45	**3469841.76**	
Adult Day Service MMAI	☒	Hour	412	376.60	11.06	**1716060.75**	
Adult Day Service MLTSS	☒	Hour	873	376.60	0.01	**3287.72**	
Adult Day Service Transportation	☐	Hour	1915	135.95	8.30	**2160857.28**	
Adult Day Service Transportation Capitated	☒	Hour	489	128.26	16.06	**1007269.39**	
Adult Day Service Transportation MMAI	☒	Hour	381	128.26	10.17	**496978.00**	
Adult Day Service Transportation MLTSS	☒	Hour	809	128.26	0.01	**1037.62**	
In-Home Service Total:							**508220404.23**
Homemaker	☐	Hour	44497	368.53	18.27	**299600218.82**	
Homemaker Capitated	☒	Hour	11356	347.69	35.34	**139535312.40**	
Homemaker MMAI	☒	Hour	8862	347.69	22.40	**69019524.67**	
Homemaker MLTSS	☒	Hour	18795	347.69	0.01	**65348.34**	
Automated Medication Dispenser (AMD) Total:							**4706700.70**
Automated Medication Dispenser Service	☐	Month	4426	7.33	40.00	**1297703.20**	
Automated Medication Dispenser Service Capitated	☒	Month	1130	6.92	40.00	**312784.00**	
Automated Medication Dispenser	☒	Month	881	6.92	40.00	**243860.80**	

GRAND TOTAL:	**536301414.57**
Total: Services included in capitation:	220354385.37
Total: Services not included in capitation:	315947029.20
Total Estimated Unduplicated Participants:	**105618**
Factor D (Divide total by number of participants):	**5077.75**
Services included in capitation:	2086.33
Services not included in capitation:	2991.41
Average Length of Stay on the Waiver:	266

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service MMAI							
Automated Medication Dispenser Service MLTSS	☒	Month	1870	6.92	40.00	517616.00	
Automated Medication Dispenser Installation	☐	One-Time	4427	1.00	50.00	221350.00	
Automated Medication Dispenser Installation Capitated	☒	One-Time	1130	1.00	50.00	56500.00	
Automated Medication Dispenser Installation MMAI	☒	One-Time	882	1.00	50.00	44100.00	
Automated Medication Dispenser Installation MLTSS	☒	One-Time	1870	1.00	50.00	93500.00	
AMD & EHRS Service	☐	Month	1990	7.33	65.00	948135.50	
AMD & EHRS Service Capitated	☒	Month	508	6.92	65.00	228498.40	
AMD & EHRS Service MMAI	☒	Month	396	6.92	65.00	178120.80	
AMD & EHRS Service MLTSS	☒	Month	840	6.92	65.00	377832.00	
AMD & EHRS Installation	☐	One-Time	1990	1.00	50.00	99500.00	
AMD & EHRS Installation Capitated	☒	One-Time	508	1.00	50.00	25400.00	
AMD & EHRS Installation MMAI	☒	One-Time	396	1.00	50.00	19800.00	
AMD & EHRS Installation MLTSS	☒	One-Time	840	1.00	50.00	42000.00	
Emergency Home Response Service Total:							7072928.88
Emergency Home Response Service	☐	Month	19984	7.33	28.00	4101516.16	
Emergency Home	☒					1906242.30	

GRAND TOTAL:		536301414.57
Total: Services included in capitation:		220354385.37
Total: Services not included in capitation:		315947029.20
Total Estimated Unduplicated Participants:		105618
Factor D (Divide total by number of participants):		5077.75
Services included in capitation:		2086.33
Services not included in capitation:		2991.41
Average Length of Stay on the Waiver:	266	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response Service Capitated		Month	5100	6.90	54.17		
Emergency Home Response Service MMAI	☒	Month	3980	6.90	34.23	940024.26	
Emergency Home Response Service MLTSS	☒	Month	8441	6.90	0.01	582.43	
Emergency Home Response Service Install	☐	One-time	2390	1.00	30.00	71700.00	
Emergency Home Response Service Install Capitated	☒	One-time	609	1.00	58.04	35346.36	
Emergency Home Response Service Install MMAI	☒	One-time	476	1.00	36.78	17507.28	
Emergency Home Response Service Install MLTSS	☒	One-time	1009	1.00	0.01	10.09	

GRAND TOTAL:	**536301414.57**
Total: Services included in capitation:	220354385.37
Total: Services not included in capitation:	315947029.20
Total Estimated Unduplicated Participants:	**105618**
Factor D (Divide total by number of participants):	**5077.75**
Services included in capitation:	2086.33
Services not included in capitation:	2991.41
Average Length of Stay on the Waiver:	266

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**30670864.38**
Adult Day Service	☐	Hour	2141	401.87	14.30	**12303772.48**	
Adult Day Service Capitated	☒	Hour	620	376.60	14.30	**3338935.60**	
Adult Day Service MMAI	☒	Hour	424	376.60	14.30	**2283401.12**	
Adult Day Service MLTSS	☒	Hour	1313	376.60	14.30	**7071003.94**	
Adult Day Service Transportation	☐	Hour	1983	136.86	10.29	**2792637.88**	
Adult Day Service Transportation Capitated	☒	Hour	574	128.26	10.29	**757562.56**	
Adult Day Service Transportation MMAI	☒	Hour	393	128.26	10.29	**518679.59**	
Adult Day Service Transportation MLTSS	☒	Hour	1216	128.26	10.29	**1604871.21**	
In-Home Service Total:							**704468281.73**
Homemaker	☐	Hour	46084	371.02	20.28	**346749177.59**	
Homemaker Capitated	☒	Hour	13341	347.69	20.28	**94069434.84**	
Homemaker MMAI	☒	Hour	9128	347.69	20.28	**64362926.41**	
Homemaker MLTSS	☒	Hour	28263	347.69	20.28	**199286742.89**	
Automated Medication Dispenser (AMD) Total:							**5458853.95**
Automated Medication Dispenser Service	☐	Month	4584	7.38	40.00	**1353196.80**	
Automated Medication Dispenser Service Capitated	☒	Month	1327	6.92	40.00	**367313.60**	
Automated Medication Dispenser	☒	Month	908	6.92	40.00	**251334.40**	

GRAND TOTAL:	**749503211.14**
Total: Services included in capitation:	380600551.80
Total: Services not included in capitation:	368902659.34
Total Estimated Unduplicated Participants:	**122447**
Factor D (Divide total by number of participants):	**6121.04**
Services included in capitation:	3108.29
Services not included in capitation:	3012.75
Average Length of Stay on the Waiver:	281

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service MMAI							
Automated Medication Dispenser Service MLTSS	☒	Month	2812	6.92	40.00	778361.60	
Automated Medication Dispenser Installation	☐	One-Time	4584	1.00	50.00	229200.00	
Automated Medication Dispenser Installation Capitated	☒	One-Time	1327	1.00	50.00	66350.00	
Automated Medication Dispenser Installation MMAI	☒	One-Time	908	1.00	50.00	45400.00	
Automated Medication Dispenser Installation MLTSS	☒	One-Time	2812	1.00	50.00	140600.00	
AMD & EHRS Service	☐	Month	2061	7.39	65.00	990001.35	
AMD & EHRS Service Capitated	☒	Month	597	6.92	65.00	268530.60	
AMD & EHRS Service MMAI	☒	Month	408	6.92	65.00	183518.40	
AMD & EHRS Service MLTSS	☒	Month	1264	6.92	65.00	568547.20	
AMD & EHRS Installation	☐	One-Time	2061	1.00	50.00	103050.00	
AMD & EHRS Installation Capitated	☒	One-Time	597	1.00	50.00	29850.00	
AMD & EHRS Installation MMAI	☒	One-Time	408	1.00	50.00	20400.00	
AMD & EHRS Installation MLTSS	☒	One-Time	1264	1.00	50.00	63200.00	
Emergency Home Response Service Total:							8905211.08
Emergency Home Response Service	☐	Month	20697	7.39	28.00	4282623.24	
Emergency Home	☒					1161009.92	

GRAND TOTAL:	749503211.14
Total: Services included in capitation:	380600551.80
Total: Services not included in capitation:	368902659.34
Total Estimated Unduplicated Participants:	122447
Factor D (Divide total by number of participants):	6121.04
Services included in capitation:	3108.29
Services not included in capitation:	3012.75
Average Length of Stay on the Waiver:	281

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response Service Capitated		Month	5992	6.92	28.00		
Emergency Home Response Service MMAI	☒	Month	4099	6.92	28.00	794222.24	
Emergency Home Response Service MLTSS	☒	Month	12693	6.92	28.00	2459395.68	
Emergency Home Response Service Install	☐	One-time	2475	1.00	40.00	99000.00	
Emergency Home Response Service Install Capitated	☒	One-time	716	1.00	40.00	28640.00	
Emergency Home Response Service Install MMAI	☒	One-time	490	1.00	40.00	19600.00	
Emergency Home Response Service Install MLTSS	☒	One-time	1518	1.00	40.00	60720.00	

GRAND TOTAL:	**749503211.14**
Total: Services included in capitation:	380600551.80
Total: Services not included in capitation:	368902659.34
Total Estimated Unduplicated Participants:	**122447**
Factor D (Divide total by number of participants):	**6121.04**
Services included in capitation:	3108.29
Services not included in capitation:	3012.75
Average Length of Stay on the Waiver:	281

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**35851872.07**
Adult Day Service	☐	Hour	2503	401.87	14.30	**14384092.72**	
Adult Day Service Capitated	☒	Hour	724	376.59	14.30	**3898911.59**	
Adult Day Service MMAI	☒	Hour	496	376.59	14.30	**2671077.55**	
Adult Day Service MLTSS	☒	Hour	1535	376.59	14.30	**8266338.80**	
Adult Day Service Transportation	☐	Hour	2318	136.87	10.29	**3264653.35**	
Adult Day Service Transportation Capitated	☒	Hour	671	128.26	10.29	**885582.71**	
Adult Day Service Transportation MMAI	☒	Hour	459	128.26	10.29	**605786.09**	
Adult Day Service Transportation MLTSS	☒	Hour	1421	128.26	10.29	**1875429.26**	
In-Home Service Total:							**823291271.63**
Homemaker	☐	Hour	53857	371.02	20.28	**405235449.56**	
Homemaker Capitated	☒	Hour	15591	347.69	20.28	**109934529.54**	
Homemaker MMAI	☒	Hour	10668	347.69	20.28	**75221702.34**	
Homemaker MLTSS	☒	Hour	33030	347.69	20.28	**232899590.20**	
Automated Medication Dispenser (AMD) Total:							**6380898.20**
Automated Medication Dispenser Service	☐	Month	5357	7.39	40.00	**1583529.20**	
Automated Medication Dispenser Service Capitated	☒	Month	1551	6.92	40.00	**429316.80**	
Automated Medication Dispenser	☒	Month	1061	6.92	40.00	**293684.80**	

GRAND TOTAL:	**875916399.27**
Total: Services included in capitation:	444783080.68
Total: Services not included in capitation:	431133318.59
Total Estimated Unduplicated Participants:	**143101**
Factor D (Divide total by number of participants):	**6120.97**
Services included in capitation:	3108.18
Services not included in capitation:	3012.79
Average Length of Stay on the Waiver:	281

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service MMAI							
Automated Medication Dispenser Service MLTSS	☒	Month	3286	6.92	40.00	**909564.80**	
Automated Medication Dispenser Installation	☐	One-Time	5357	1.00	50.00	**267850.00**	
Automated Medication Dispenser Installation Capitated	☒	One-Time	1551	1.00	50.00	**77550.00**	
Automated Medication Dispenser Installation MMAI	☒	One-Time	1061	1.00	50.00	**53050.00**	
Automated Medication Dispenser Installation MLTSS	☒	One-Time	3286	1.00	50.00	**164300.00**	
AMD & EHRS Service	☐	Month	2408	7.39	65.00	**1156682.80**	
AMD & EHRS Service Capitated	☒	Month	697	6.92	65.00	**313510.60**	
AMD & EHRS Service MMAI	☒	Month	477	6.92	65.00	**214554.60**	
AMD & EHRS Service MLTSS	☒	Month	1477	6.92	65.00	**664354.60**	
AMD & EHRS Installation	☐	One-Time	2408	1.00	50.00	**120400.00**	
AMD & EHRS Installation Capitated	☒	One-Time	697	1.00	50.00	**34850.00**	
AMD & EHRS Installation MMAI	☒	One-Time	477	1.00	50.00	**23850.00**	
AMD & EHRS Installation MLTSS	☒	One-Time	1477	1.00	50.00	**73850.00**	
Emergency Home Response Service Total:							**10392357.36**
Emergency Home Response Service	☐	Month	24188	7.39	28.00	**5004980.96**	
Emergency Home	☒					**1352786.40**	

GRAND TOTAL:	**875916399.27**
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Total Estimated Unduplicated Participants:	**143101**
Factor D (Divide total by number of participants):	**6120.97**
Services included in capitation:	3108.18
Services not included in capitation:	3012.79
Average Length of Stay on the Waiver:	281

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response Service Capitated		Month	7002	6.90	28.00		
Emergency Home Response Service MMAI	☒	Month	4791	6.90	28.00	**925621.20**	
Emergency Home Response Service MLTSS	☒	Month	14834	6.90	28.00	**2865928.80**	
Emergency Home Response Service Install	☐	One-Time	2892	1.00	40.00	**115680.00**	
Emergency Home Response Service Install Capitated	☒	One-time	837	1.00	40.00	**33480.00**	
Emergency Home Response Service Install MMAI	☒	One-time	573	1.00	40.00	**22920.00**	
Emergency Home Response Service Install MLTSS	☒	One-time	1774	1.00	40.00	**70960.00**	

GRAND TOTAL:	**875916399.27**
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